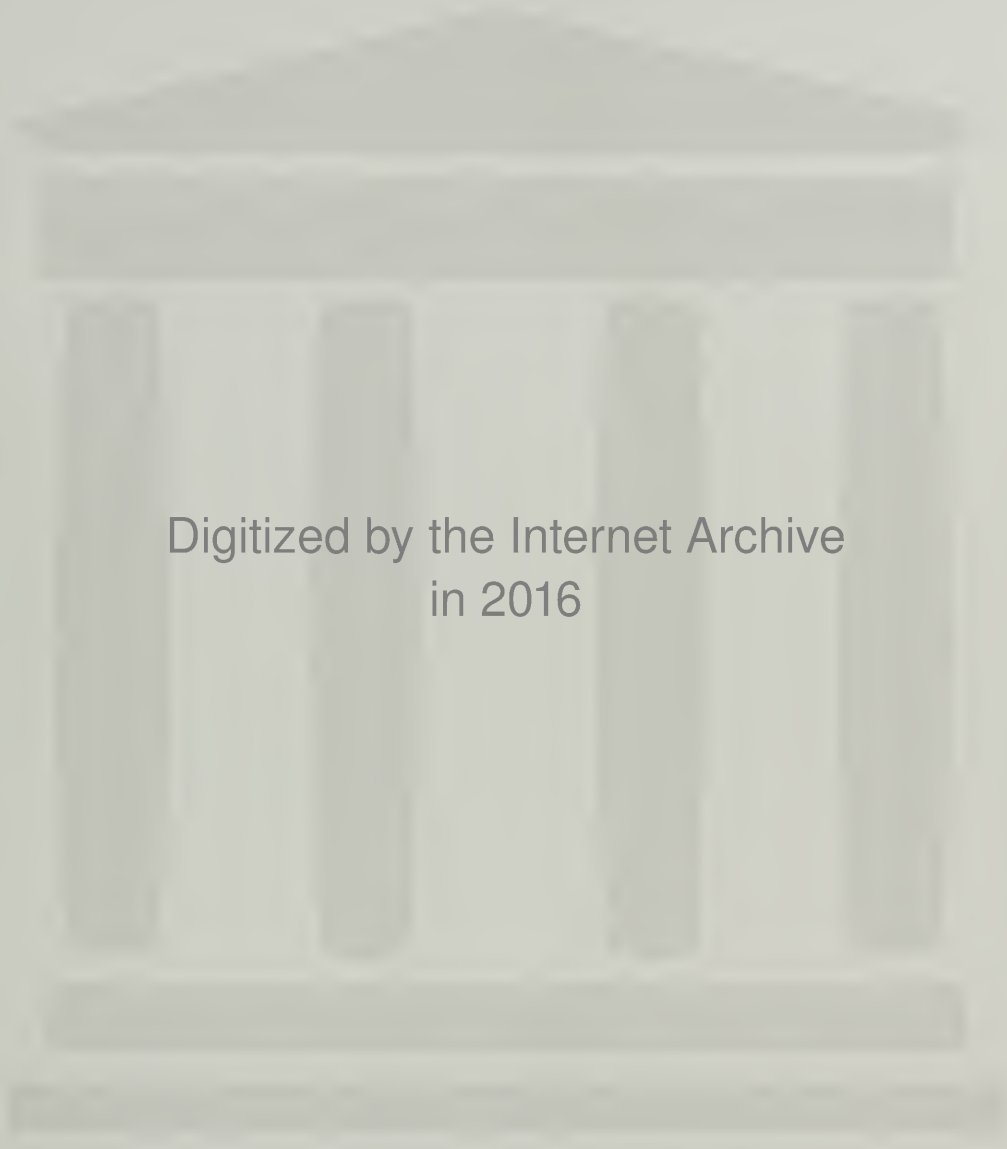
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IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

Volume 134, Number 1 July, 1968

Clinical Articles

Differentiation of a Bifid Ureter from Ureteral Diverticula

A Case of Post-Pericardiotomy Syndrome Pathogenical Consideration

Coronary Artery Occlusion with Myocardial Infarction in a Twelve Year Old Boy

Fusion of the Labia Minora

Surgical Grand Rounds

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The Severely Affected Rh-Sensitized Pregnancy

SPECIAL REPORT

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For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

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BLUE SHIELD REPORT FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol 2, No. 7 **July, 1968**

Dear Doctor:

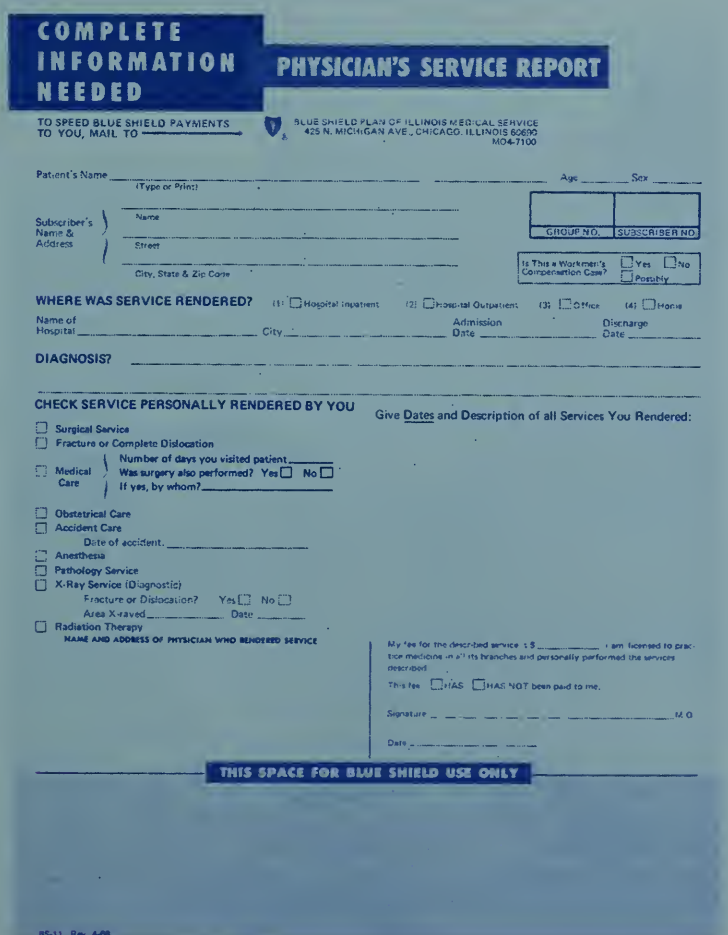
We have recently offered a new Blue Cross and Blue Shield program to supplement the benefits of Medicare for our direct-pay over 65 subscribers. Direct subscribers over 65 formerly held our Series 65 Major Medical Plan which included deductible and coinsurance features. The great majority have converted to our new **Blue Cross 65 and Blue Shield 65** which is simpler to understand, superior in dollar benefits, and facilitates claims processing.

Our new Blue Shield 65 will pay 20% of the physician's Usual and Customary charges for the full Medicare scope of medical and surgical services for hospital bed patients. It will pay 20% of the physician's Usual and Customary charges for visits to certificate holders in extended care facilities while the member is receiving Medicare benefits. It will pay 20% of the physician's Usual and Customary charges for surgical services for accident care in the doctor's office or in the outpatient department of the hospital.

No special forms are required for this program whether you accept Medicare assignment or bill your patient directly, simply file your Blue Shield 65 claim on our regular **Physician's Service Report** reproduced below. Indicate the service you performed, your fee for each service, and the dates of service.

We will also offer this superior program to those subscribers over 65 who are Blue Cross-Blue Shield group members. We feel that this program will not only benefit subscribers over 65 but will facilitate the completion of claims for you and your office assistant by using our standard Physician's Service Report.

For additional information, please contact one of the Special Representatives of our Professional Relations Department, MO 4-7100, extension 235, Blue Shield Plan of Illinois Medical Service, 425 North Michigan Avenue, Chicago, Illinois 60601.



COMPLETE INFORMATION NEEDED

PHYSICIAN'S SERVICE REPORT

TO SPEED BLUE SHIELD PAYMENTS TO YOU, MAIL TO —— BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE 425 N. MICHIGAN AVE., CHICAGO, ILLINOIS 60690 MO4-7100

Patient's Name _____ (Type or Print) _____ Age _____ Sex _____

Subscriber's Name & Address: Name _____ Street _____ City, State & Zip Code _____

GROUP NO. | SUBSCRIBER NO.

Is This a Workmen's Compensation Case? ☐ Yes ☐ No ☐ Possibly

WHERE WAS SERVICE RENDERED? (1) ☐ Hospital Inpatient (2) ☐ Hospital Outpatient (3) ☐ Office (4) ☐ Home

Name of Hospital _____ City _____ Admission Date _____ Discharge Date _____

DIAGNOSIS? _____

CHECK SERVICE PERSONALLY RENDERED BY YOU

Give Dates and Description of all Services You Rendered:

☐ Surgical Service
☐ Fracture or Complete Dislocation
☐ Medical Care — Number of days you visited patient _____ Was surgery also performed? Yes ☐ No ☐ If yes, by whom? _____
☐ Obstetrical Care
☐ Accident Care — Date of accident: _____
☐ Anesthesia
☐ Pathology Service
☐ X-Ray Service (Diagnostic) — Fracture or Dislocation? Yes ☐ No ☐ Area X-rayed _____ Date _____
☐ Radiation Therapy

NAME AND ADDRESS OF PHYSICIAN WHO RENDERED SERVICE

My fee for the described service is $ _____. I am licensed to practice medicine in all its branches and personally performed the services described.

This fee ☐ HAS ☐ HAS NOT been paid to me.

Signature _____ M.D.

Date _____

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ASK BLUE SHIELD

• • • ABOUT MEDICARE

Q How should I bill my pathology and radiology services to hospital in-patients when Part A benefits are exhausted?

A Radiology and pathology services should be billed on SSA 1483 form when hospital in-patients are no longer eligible under Part A. All services billed on SSA 1483 will be reimbursed under Part B. Reasonable charges are 100% reimbursable but may not be applied toward the Part B deductible. These changes became effective April 1, 1968.

Q I have a patient who exhausted his hospital benefits in mid December who wishes to apply for the additional 60 day lifetime reserve available from January 1, 1968. How are charges for this service handled from the date original benefits were used until he chooses to use the additional 60 days of lifetime reserve?

A Charges for the period between the time his original benefits were exhausted until he draws from his 60 day lifetime reserve would not be covered.

Q How is the Part B blood deductible and the Part B $50 deductible and co-insurance related?

A Reimbursement for blood and packed cells furnished after the patient has received three pints in a calendar year will be subject to the Part B $50 deductible and co-insurance. Expenses incurred in meeting the blood deductible do not apply toward the Part B $50 annual deductible or for reimbursement purposes even though the Part B deductible for any calendar year is satisfied in whole or part during the last three months of the calendar year. There is no carry over credit allowed toward the blood deductible in the following calendar year.

Q Are withdrawal treatments for narcotic addicts covered services under Part B of the Medicare program?

A Payment may be made for withdrawal treatments when they are provided by the physician or are provided directly under his personal supervision.

Drugs provided in connection with withdrawal treatments are covered if they cannot be self-administered and meet all other requirements.

Portable X-Ray Services

Before we are able to make payment for portable X-ray tests made in the home or extended care facility, we must have the name of the physician who ordered the service on the itemized statement or form SSA 1490.

Routine screening procedures and tests in connection with routine physical examinations are excluded from coverage. Bills for portable X-ray services involving the chest should include the reason the X-ray was required.

The scope of covered benefits for portable X-ray is defined as:

1. Skeletal films involving the extremities (the arms and legs), pelvis, vertebral column, and skull;
2. Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations);
3. Abdominal films which do not involve the use of contrast media.

Name, Address, and Signature of Physician Needed before Medicare claims can be processed, it is necessary for the Part B carrier to have the name and address of the attending physician. When claims are assigned, payments will be mailed to the physician at the address indicated on SSA 1490 *Request for Payment* form.

It is preferable to have the physician's signature on form SSA 1490 when cases are assigned. However, he may authorize a person on his staff (nurse, secretary, billing clerk, etc.) to sign his name or use a name stamp. The appropriate box on the SSA 1490 should be checked to indicate that he is a medical doctor. The telephone number may facilitate future contact when necessary.

Our Government Contracts Division reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during May for over 79,000 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding $4,400,000. For the year 1968 through May, payments have been made on over 334,000 cases for about $19,000,000.

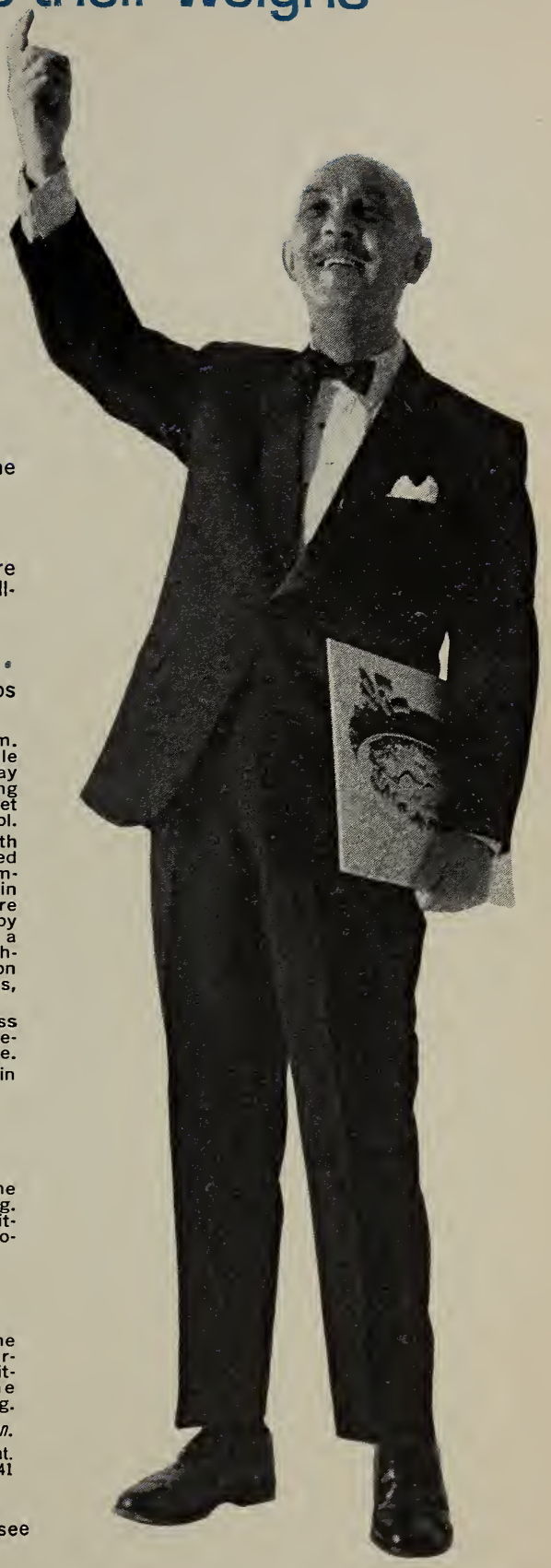
The number of cases processed in May under Part A exceeded 72,000 with payments to providers amounting to about $17,000,000. For the year 1968 through May, over 347,000 cases have been processed and payments to providers have exceeded $92,000,000.

NOTICE

To help speed Medicare payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

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OBEDRIN MENU PLAN . . .

provides adequate protein intake and helps 'overweights' establish better eating habits.

DOSAGE: Obedrin-LA—1 daily, usually at 10 a.m. Obedrin Tablets and Capsules—1 tablet or capsule at 10 a.m. and 3 p.m. A third tablet or capsule may be given in the evening to discourage late evening snacks. Obedrin tablets are grooved so a half-tablet can be taken if it is found sufficient for appetite control.

CAUTION: Should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates, and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such cases, withdrawal of medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

SIDE EFFECTS: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage.

SUPPLY: Obedrin-LA—Bottles of 50 and 250. Obedrin Tablets and Capsules—Bottles of 100 and 1000.

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Each two-layer tablet contains: Methamphetamine Hydrochloride*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit-forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg.

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Tablets—Capsules

Each tablet or capsule contains Methamphetamine Hydrochloride, 5 mg.; Pentobarbital, 20 mg. (Barbituric Acid derivative; Warning: May be habit-forming); Ascorbic Acid, 100 mg.; Thiamine Mononitrate, 0.5 mg.; Riboflavin, 1 mg.; Niacin, 5 mg.

CAUTION: Federal law prohibits dispensing without a prescription.

*U.S. Patent Nos. 2,736,682; 2,809,917; 2,809,916; 2,809,918 and pat. pend. **U.S. Patent Nos. 2,648,609; 2,799,241

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New Test Detects Abnormal Development in Children

A graphic new test has been devised to detect abnormal development in infants and small children, the U. S. Public Health Service announced.

The new test, called the Denver Developmental Screening Test, is simple to administer, easy to score, and can be used for repeated evaluations of the same child. Developed under a National Institutes of Health General Research Support Grant, the new screening tool has been recommended to the Nation's pediatricians by the American Academy of Pediatrics and is now being used in Project Head Start.

Under the test format, an individual child's performance can be compared quickly with other children on a standardized scale for four major functional areas: gross motor, fine motor-adaptive, language, and personal-social.

The new test is not an intelligence test, according to developers Dr. William K. Frankenburg and Dr. Josiah B. Dodds of the University of Colorado School of Medicine. It is intended mainly as a screening device to detect children with developmental delays.

Test Is Not Diagnostic

"It enables the examiner to note whether the development of a particular child is within normal range," said Dr. Frankenburg. "The test does not enable one to make a diagnosis; it is intended only to alert the examiner to the presence of a developmental problem which needs further investigation. Of course, when developmental delays are detected during infancy and the preschool years, it significantly increases the opportunities for effective therapy."

The new test is made up of 105 test items selected from a number of developmental and preschool intelligence tests. These items were administered to 1,036 healthy Denver, Colorado, children between the ages of two weeks and six years. The ages at which 25, 50, 75, and 90 percent of the children passed each item were calculated for 25 different age categories. In the final screening test, which resulted from the normative data gathered by the investigators, each item is represented by a horizontal bar placed along the age continuum. Various points on the bar illustrate the specific ages at which a percentage of the children passed an item. For example, for the test item "Walks Well," the left-hand end of the bar designates the age (11.2 months) at which 25 percent of the children could walk well and the right-hand end of the bar the age (14.3 months) at which 90 percent of the children could walk well.

Collar Color of Fathers

As the developmental screening test was being standardized, the investigators also calculated norms for boys, girls, children whose fathers were "blue collar" employees, and children whose fathers were "white collar" employees. According to Dr. Frankenburg, who did not include differences in various segments of the sample on the final test, there were few marked differences between the ages at which boys and girls performed individual test items.

"During the first two years of life there were also no marked differences in the ages at which children of parents from different occupational groups could perform the test items," said Dr. Frankenburg. "After two years of age, the children of white collar workers performed a number of language items at an earlier age than children of blue collar workers."

Using General Research Support funds, Drs. Frankenburg and Dodds are currently investigating the development of 1,000 Denver children whose fathers are in unskilled occupations with the idea of possibly creating a separate test for use in examining these children. Neurological and developmental problems are more likely in children from this group, according to Dr. Frankenburg.

The Division of Research Facilities and Resources, National Institutes of Health, administers the General Research Support grants under which the Denver Development Screening Test was devised.



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

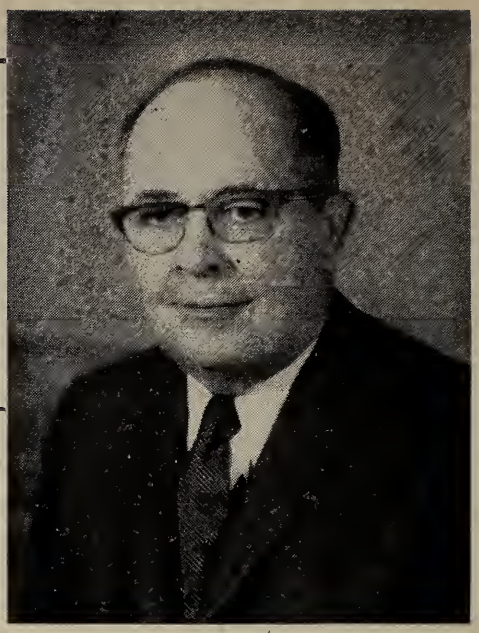
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DOW

The president's page



Philip G. Thomsen, M.D.

You, the members of ISMS, talked cold turkey to us officers two years ago. In a poll conducted by Opinion Research Corporation, a cross-section of you appraised the society on many points. Many of your responses were disturbing. For that very reason they have goaded us to think . . . and act.

One question was: How well does ISMS represent the wishes of the membership as a whole? Of the 1,145 members who responded, 9 per cent gave the society an excellent rating on this score; 32 per cent, good; 26 per cent, fair; 14 per cent, poor. The remaining 19 per cent had no opinion.

In short, we could do a better job of learning *your* views on controversial issues . . . of putting *your* views into prompt and spirited action.

And that's just what we intend to do . . . in a fresh and exciting way.

We're mailing you a questionnaire this month on many issues that are vital to you . . . to medical practice . . . to medicine's relations with the public and with the state and nation. We're asking you to register your opinions on such questions as rising health costs . . . the physician shortage . . . abortion . . . welfare problems.

You need not sign your name unless you wish to do so. Your sentiments are enough.

Your responses will guide us in every area of action, including our legislative goals. They will guide my fellow officers and me when we speak for the society at rostrums, on TV and radio, and to the press. They will permeate my addresses before county medical societies and civic groups.

Phil Thomsen will not be speaking just for himself or for the Board of Trustees—but for you. And by talking in mighty unison, your society will be heard better in the General Assembly . . . in state and federal agencies . . . in journalistic circles, and everywhere else.

Let's scotch the widely-held notion that organized medicine speaks only for a segment of its members. Give us a majority voice by filling out and returning the questionnaire. Help me to work for each of you . . . and all of you!

IMJ
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volume 134, number 1 July, 1968

Differentiation Of A Bifid Ureter From Ureteral Diverticula

By Arnold B. Rubenstein, Victor R. Jablokow and Frederick A. Lloyd/Chicago

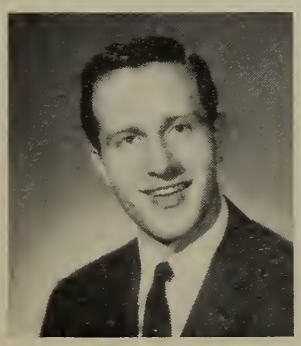
Ureteral diverticula have been classically divided into congenital or true and acquired, or false groups. A congenital ureterial diverticulum contains all layers of the ureteral wall. The false diverticulum does not contain muscular tissue in its configuration and usually is located proximal to an area of ureteral obstruction. It is an acquired entity that results from the evagination of mucosal lining of the ureteral wall through its muscular coat.

The differentiation between a bifid ureter and multiple congenital ureteral diverticula poses no problem.[1,2] However, considerable confusion still exists as to the difference between a blind-ending bifid ureter and a single congenital ureteral diverticulum. In 1933 Kretschmer emphasized the difference stating that the bifid ureter is an abortive attempt to duplication which results from premature ureteral bud cleavage or Wolffian duct budding.[3] The true diverticulum can occur either from malformations similar to those of an incompletely formed bifid ureter or secondary to a congenital weakness in the ureteral wall.[4]

Radiological Examination Necessary

The differential diagnosis of a blind-ending bifid ureter and a diverticulum rests entirely on radiological examination, as both have similar histologic appearance, and there are no differentiating clinical symptoms. Radiologically, the bifid ureter is long, narrow, and is usually located close to the ureterovesical junction. It joins the normal ureter at an acute angle, and the length of the bifid ureter is much greater than its luminal diameter.[5] The single congenital diverticulum, on the other hand, is commonly a round to ovoid extra-ureteral sac. The length often approaches the size of its lumen, and the point of origin is not necessarily at an acute angle from the normal ureter. Furthermore, its position is not always juxtavesical.

In 1947, Culp found 52 ureteral diverticula reported in the literature to that date. Only ten of them were true congenital diverticula. Fourteen of the 52 were actually bifid ureters.[5] Though the two entities (bifid ureters and ureteral diverticula) may have a similar etiology and may be varying gradients of the same abnormality, anatomically they are distinct, and the following two cases attempt to illustrate the differences.



Arnold B. Rubenstein, M.D., is a Surgical Resident in Urology at the Veterans Administration Hospital, Hines. He received his M.D. from the Chicago Medical School and served his internship at Michael Reese. He has also served a residency in Urology at the Mayo Clinic. Also participating in the preparation of this paper were Victor R. Jablokow, M.D. from the Department of Pathology, Hines V.A. Hospital and Frederick A. Lloyd, M.D., from the Department of Surgery, Hines.

Case No. 1

A 69-year old Negro male was admitted because of frequency and dysuria of three months' duration. Physical examination, including prostate, was not remarkable. Urine analysis revealed pyuria and bacteriuria, and a culture grew coliform organisms. Cystoscopic examination was within normal limits, but an excretory urogram suggested a duplication of the ureter on the right side. The retrograde pyeloureterogram on that side showed a diverticulum-like structure or bifid ureter (Fig. 1). The patient was explored, and the ureter was identified in the retroperitoneal space. Lying alongside the normal ureter and slightly adherent to it was a sac-like structure, approximately five cm. in length, with a lumen which entered the ureter one cm. above the entrance of the ureter into the bladder. The lesion was excised.

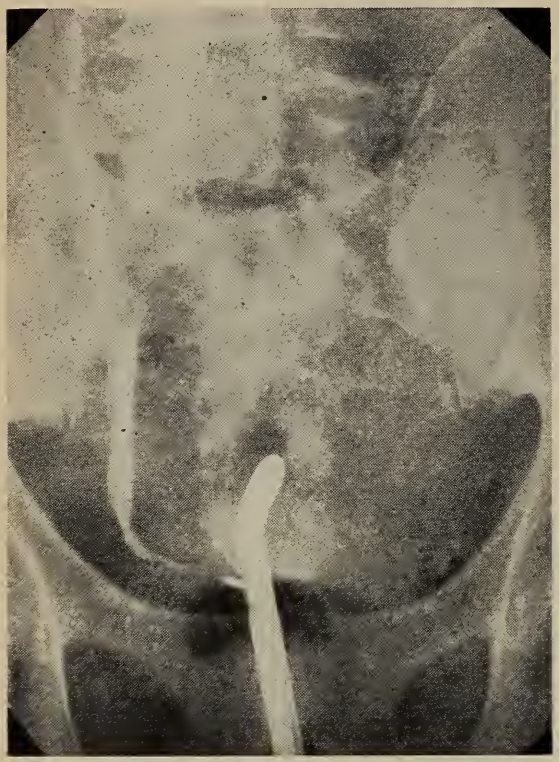


Fig. 1. Retrograde pyeloureterogram showing diverticulum-like structure suggesting a duplication of the ureter on the right side.

The specimen received in the laboratory revealed an elongated, cylindrical structure 4.5 cm. in length and approximately 0.6 cm. in diameter. The structure had an opening at one end while the other end was closed in a sac-like fashion.

This diverticulum-like structure had smooth mucosal lining with focal hemorrhagic discoloration. Histologically it was lined with transitional epithelium. The wall contained all layers of the ureteral wall (Fig. 2).



Fig. 2. Section through the wall that contains all normal layers of the ureter.

The patient's post operative course was uneventful, and he was discharged without symptoms. Patient has had no complaints twenty months after surgery, and urine cultures have remained sterile.

Case No. 2

A 38-year old white female patient was admitted because of sudden onset of right lower quadrant pain extending into the right flank. She stated that for the last several months she had experienced intermittent right lower quadrant pain but never as severe as the present episode. Urine analysis was normal. Excretory urogram was done and revealed a diverticulum-like structure located at the junction of the middle and lower thirds of the right ureter. The patient was taken to surgery, and a twisted, infarcted dermoid cyst (benign cystic teratoma) of the right ovary was found.

Right salpingo-oophorectomy was done. Patient tolerated procedure well and has been asymptomatic for twenty-one months. No definitive therapy for the ureteral diverticulum was attempted.

Discussion

With the presentation of the above cases, an attempt is made to differentiate between the bifid-type ureter and a true, single, congenital ureteral diverticulum. As illustrated in our radiologic studies, the lesion of Case No. 1 originated adjacent to the bladder and was long and narrow. This was consistent with a bifid-type ureter. Case No. 2 demonstrated a shorter lesion with a wider lumen that originated at the junction of the middle and lower thirds of the normal ureter. This fit the criteria of a ureteral diverticulum.

As was illustrated by Fig. 2, the wall of the blind-ending bifid ureter contained all normal layers. The histologic pattern of Case 2 is expected to be the same, but no specimen was obtained because of an acute condition in another organ system. This case was asymptomatic urologically, and so one wonders whether or not the congenital diverticulum may be more common than reported, in that many cases lack clinical symptoms. In the case reported, the lesion was discovered fortuitously.

Summary

Two case reports of ureteral lesions are presented attempting to illustrate the anatomic differences between a bifid-type ureter and a single congenital ureteral diverticulum.

References

1. Williams, J. T., Goodwin, W. E.: Congenital Multiple Diverticula of the Ureter, Brit. J. Urol. 37:299-301, June, 1965.
2. Norman, Calvin H., Jr. and Dulowy, Jerome: Multiple Ureteral Diverticula, J. Urol. 96:152-154, 1966.
3. Kretschmer, H. L.: Duplication of the Ureters at their Distal Ends, J. Urol. 30:61-63, 1933.
4. Rank, W. B., Mellinger, G. T., Spiro, E.: Ureteral Diverticula: Etiology and Considerations, J. Urol. 83:566-570, 1960.
5. Culp, O. S.: Ureteral Diverticula: Classification of the Literature and Report of an Authentic Case, J. Urol. 58:309-321, 1947.



Fig. 3. Excretory urogram reveals a diverticulum-like structure of the right ureter at the junction of the middle and lower thirds.

Exercise Care in Writing Orders

False entries, alterations or erasures without satisfactory explanation will cause the entire record to be suspect and can destroy the doctor's credibility as a witness. Erasures are more difficult to explain than parts which are simply crossed out. If an alteration becomes necessary, a single line should be passed thru each sentence with no effort made to obliterate the words. The signature of the person making the correction should follow together with the date of the change.

Legible writing is essential when orders are to be carried out by others. This is especially true where symbols or abbreviations are used. A nurse misread the dram symbol in a prescription as an ounce symbol and administered three ounces of paraldehyde instead of the prescribed three drams. A written lt. (for left) was read as an rt. (for right), and the wrong foot was operated. The Doctor and the Law, The Patient's Record In Court. No. 2, by the Law Department of the Medical Protective Company, Fort Wayne, Ind. (1968).

THE VIEW BOX

By Leon Love, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School

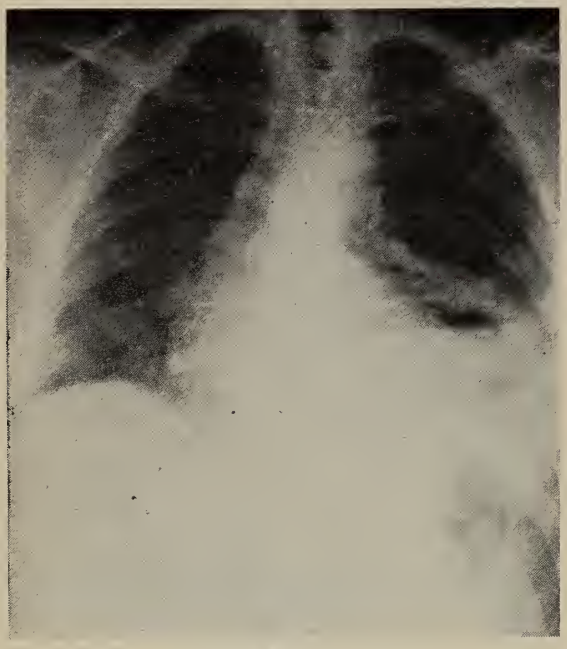


Fig. 1

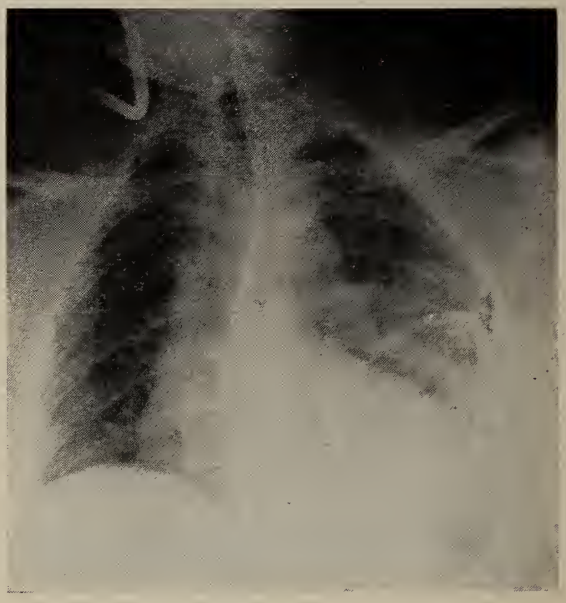


Fig. 2

History. This 34-year-old male patient was brought into the hospital following an automobile accident. He complained of shortness of breath when lying on his left side. Physical examination revealed some dullness at the left base. The blood pressure wass 100/60.

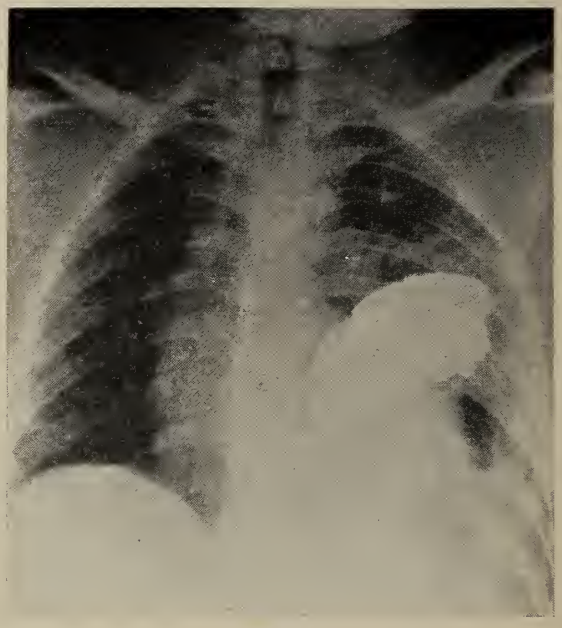


Fig. 3

What's your diagnosis?

(Answer on page 102)

Medical Progress in the Severely Affected Rh-Sensitized Pregnancy

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A SYMPOSIUM

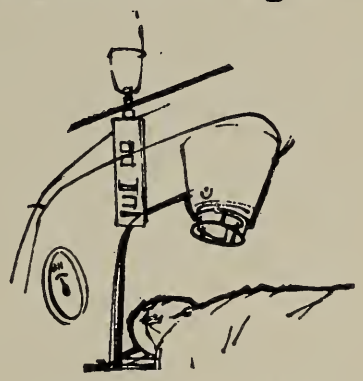
The patient with Rh-isoimmunization presenting with an infant with far-advanced erythroblastosis in utero is a special problem warranting intensive, aggressive care and attention. Recent advances notwithstanding, if we are to continue to improve the previously very poor outlook for these infants, we must delve deeply to assess our approach and seek means to correct deficiencies. Additionally, unexplored areas of potential relevance are probed.

Case Presentations (Dr. Alan Silverman)

Case 1. B. W. (M.R.H. # 237-217) is a 34 year old white female, gravida 3, para 3 with one living child. Her estimated date of confinement was April 17. She is Rh negative and sensitized. She was admitted on March 8. This patient gives a history of fetal loss with her last pregnancy. An amniocentesis performed elsewhere at 33½ weeks' gestational age showed a spectrophotometric optical density peak at 450mμ of 0.26 units. This was repeated on March 3 at 34 weeks and revealed a curve consistent with meconium. The urinary estriol on March 7 was 5 mg./24 hr. On admission the patient's general physical examination was within normal limits. The fetal weight was felt to be small. Fetal heart tones were normal. Fetal movements were good. The cervix was long and closed. Her admission diagnosis was severe erythroblastosis fetalis, with the fetus in dire jeopardy. On March 8 the patient underwent classical cesarean section plus bilateral Irving tubal ligation. The post-operative course was uneventful and she was discharged on the seventh post-operative day.

The infant girl weighed 1540 gm. and was described as pale with a good cry. The cord hemoglobin was 2.3 gm.% with a hematocrit of 11%. The infant underwent an immediate exchange transfusion with packed red blood cells. The pre-exchange hemoglobin was 5 gm.%; the post-exchange 23 gm.%. The pre-exchange bilirubin was 8.4 mg.%, with a free fraction of 4.1 mg.%; post-exchange 7.5 mg.% with a free fraction of 3.0 mg.%. The same evening the infant underwent a second exchange transfusion. The pre-exchange transfusion bilirubin was 10.8 mg.%; post-exchange 8.0 mg.%. The infant was digitalized. Two days after delivery the infant was noted to have coffee-ground emesis. Her bilirubin was 25.2 mg.% with a glucuronide fraction of 16.8 mg. %. Liver damage was suspected because of the increased glucuronide fraction and a possible bleeding tendency.

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The infant was noted to have a high-pitched cry and this brought up the question of a possible central nervous system bleed. On the third day after delivery the infant underwent another exchange transfusion. Pre-exchange bilirubin was 17.5 mg.%; post-exchange 11.5 mg.%. Subsequently on the same day, the infant was noted to have abdominal distention. A flat plate of the abdomen was normal. The SGOT and SGPT were elevated, confirming the possibility of liver damage. On

March 21 the hemoglobin was down to 9.5 gm.%. This was a decrease of 4.3 gm.% in 5 days. The infant was transfused with packed red cells. Because of persistent heart murmur, a cardiological evaluation was obtained. The impression was a possible patent ductus arteriosus, but no further treatment was advised at this time. The infant was discharged on April 10, at age one month in good condition. Coombs test at this time was still strongly positive.

Case 2. L. B. (M.R.H. # 161-244) is a 34 year old Negro female, gravida 11, para 8, abortus 2, with 3 living children, blood type B, Rh negative, and serology negative. Her estimated date of confinement was May 11, 1967. She was first seen in the prenatal clinic in December, 1966 during her early second trimester. Her past obstetrical history reveals 3 living children, 3 stillbirths, 2 neonatal deaths and 2 abortions. Her first pregnancy was in 1949 and was associated with antepartum bleeding for which she was transfused. The infant was stillborn. This was followed by 2 normal term deliveries; then there was 2 erythroblastotic infants both of which died (the second after exchange transfusions at the age of 2 months). Her sixth and seventh pregnancies terminated in first trimester abortions. Her eighth pregnancy was uneventful and her ninth and tenth both terminated in stillbirths. She had renal infection with a positive urine culture during this pregnancy, treated with Ampicillin. Her husband is Rh positive, homozygous. Her Rh antibody titer at 18 weeks' gestation was 1:32 and remained at 1:64 to the thirtieth week.

On February 24 at 29 weeks' gestation, an amniocentesis revealed yellow fluid. Spectrophotometrically, at 450mμ the delta-O.D. was 0.23 units, consistent with a severely affected infant. At 30 weeks' gestation on March 4, the patient had an intrauterine fetal transfusion with 140 ml. of type O, Rh negative packed red cells. On March 19 the patient was readmitted for a second intrauterine transfusion at 32 weeks' gestation. This time the fetus was transfused with 160 ml. of packed red cells. The patient was discharged with plans to readmit in 2 weeks for delivery.

At 29 weeks the estriol was 2.2 mg/24 hr. which is normal; at 30 weeks' it was 3.4 and 6.9; at 32 weeks' it was 4.9 and 4.1. Simultaneously, there were progressively rising pregnanediol levels.

On April 3 she was readmitted at 34 weeks' gestation. The estimated fetal weight was 4½ lbs. The cervix was long and closed. On April 5 the patient underwent a low cervical cesarean section plus bilateral tubal ligation. The mother's postoperative course was uncomplicated and she was discharged on her seventh postoperative day.

The infant weighed 2005 gm. It was pink with good respiration and good heart beat. There was no splenomegaly. The liver was palpated 1-2 cm. below the right costal margin. The general physical examination was within normal limits. There were 2 puncture marks noted on the right lumbar region and one in the right inguinal area. Cord blood revealed a hemoglobin of 17.8 gm.% and a hematocrit of 48%. The cord blood was type O, Rh negative, Coombs negative. It contained 98 per cent adult hemoglobin. The bilirubin of the cord blood was 2.9 mg.%. On the first day of life the infant's bilirubin rose to 18 mg.%; then down to 15 mg.%; and finally to 12.4 mg.% and remained at these levels for the rest of the course. An x-ray on April 6 was obtained because the infant had abdominal distention, and it was interpreted as normal. At age 20 days the infant was feeding well, color was good, cry was good. The blood type was still 0, Rh negative.

Principles of Management (Dr. William M. Alpern)

These two cases are actually quite similar, but the time of appearance at the clinic is the critical distinguishing aspect. Both had a history of previous fetal losses due to erythroblastosis and presented with current evidence of severe intrauterine erythroblastosis. The first patient was seen originally at 34 weeks' gestational age. We felt that, with evidence of a high optical density peak of the amniotic fluid, it was perhaps a little too late to do an intrauterine transfusion. The reasoning behind this was that the mortality from a preterm delivery at this time would probably be equal to or less than that associated with intrauterine transfusion. The original amniocentesis was done at another hospital. We repeated the tap and found that the analysis was compatible, in our opinion, with the presence of meconium in the fluid. We were unable to interpret the graph further from the

standpoint of bilirubin analysis. Perhaps this meant impending fetal distress or even demise. An estriol determination revealed a rather low level. Amniography did not show evidence of hydrops fetalis. Prompt delivery was felt to be indicated. As was described, at delivery the infant was seriously ill. Under expert pediatric management, it survived.

We performed an amniocentesis on the second patient at 28 weeks' gestational age. Here, too, the fluid analysis showed a high bilirubin peak. The history of fetal loss was similiar to the first case. Amniocentesis was repeated to verify the fact that severe fetal embarassment existed. We elected to perform an intrauterine transfusion. The patient at that time was in her twenty-ninth week of gestation. We carried out 2 intrauterine transfusions 2 weeks apart, and delivered the patient approximately 3 weeks after the last intrauterine transfusion. There was some difficulty with the second intrauterine transfusion. However, after managing to place the needle in the peritoneal cavity, the blood was administered with ease. The baby was delivered by cesarean section at a similar period of pregnancy as the first case presented, namely 35 weeks. The infant demonstrated erythroblastosis. Its clinical condition at birth was nevertheless quite good. It had a good cord hemoglobin and it responded well to neonatal care. The verification of our intrauterine transfusion was by determining the presence of 98 per cent adult hemoglobin in the cord blood sample. Ordinarily, fetal hemoglobin constitutes about 95 to 98 per cent. The adult hemoglobin is evidence of circulating transfused blood, because adult blood was used to transfuse the fetus.

Optical Density Peaks Established

We have cared for 159 Rh sensitized pregnant patients over the last few years. On the basis of our experience, we have constructed a probability graph comparing the optical density of the amniotic fluid with the cord hemoglobin at birth. We have divided this basically into 3 categories: low, mid and high range values of optical density peaks at 450mμ. The low range is from zero to 0.07 units. In this range will usually fall all Rh negative infants and all mildly affected or unaffected Rh positive infants. This graph indicates a predictable hemoglobin range of 12.5 gm.% to above 18 gm.%, which is rather good for a newborn infant. The midrange values are from 0.07 to 0.17 units. The lower the optical density value in the midrange, the less affected the infant, and the higher value, the more seriously involved. The range of hemoglobin in this group is from approximately 11 to 6 gm.%.

The high range of values is from 0.17 units up. Herein lie the seriously ill infants who will most likely succumb if no treatment is performed or early delivery is not carried out. We have a small group of control studies in the very beginning of our investigation when we were not performing intrauterine transfusions. Many of these cases came to us quite late and they all had values above 0.17 units. Therapy was rather simple in that most of the time nothing was done or delivery was effected too late. All of these infants succumbed to their disease. Most were stillborn. The ones that were born alive were usually hydropic. The hydropic infant is basically untreatable.

Therapy for the 3 ranges is rather simple. The patient in the low range from 0 to 0.07 can safely be delivered at or near term either by elective induction of labor (if conditions are favorable) or by awaiting the spontaneous onset of labor. The cases whose values fall between 0.07 and 0.17 should be watched very closely. Amniocentesis should be repeated each week or two depending on whether the value is in the lower or the upper part of the midrange. The therapy here consists mainly of preterm delivery between 34 and 37 weeks. In our experience the great majority of these patients will be delivered by abdominal route, because at this stage of pregnancy we feel that a difficult or lengthy induction of labor probably jeopardizes the fetus to some extent. In the upper range we feel that there are two forms of therapy available to the patient. If the patient presents prior to her thirty-second week of pregnancy, we feel that intrauterine transfusion is probably indicated. After 32 weeks of gestation (and closer to 34 weeks), immediate delivery is probably indicated if hydrops fetalis is not present. The cases presented were managed with these two types of therapy.

Results Reported

Our results in these 159 cases include an

uncorrected mortality of approximately 35 per cent, representing 55 babies that were lost. Although this does not sound like a very good figure, it reflects the special population of severely affected infants with which we are dealing. Most of the cases are referred to us. In the last two years, most have been of the severe variety and many have appeared too late, with hydropic or dead infants when they were first examined by us. When one divides our material into the low, mid and high ranges, the figures are a little more encouraging. The low range 0 to 0.07 represents 75 cases of which 74 survived. The one infant lost was delivered at term, after a spontaneous labor, and died during an exchange transfusion. In retrospect, it is the feeling of the group that the exchange transfusion was perhaps not indicated and this infant might have survived had it not been done. There is still a definite risk in exchange transfusion and, therefore, it should not be undertaken lightly. The uncorrected mortality among the 75 patients in the low range was 1.3 per cent. Actually this should probably have been zero.

In the midrange, we have the moderately sick and sometimes quite sick infants. There were 31 patients in this group, and 11 infants succumbed. One probably died as a result of amniocentesis. We probably lacerated a placental vessel, although this could not be definitely demonstrated. This infant died within 24 hours after the amniocentesis. The mortality in the midrange is 35 per cent. This is quite high. However, many were very sick infants and the majority of these, surprisingly, were neonatal deaths. Most occurred near the beginning of our series. Since then we have better organization, including a "team" approach, and a better idea of how to take care of these seriously ill infants. Our mortality has improved in the last year or two.

In the higher range (above 0.17) we have 52 cases. Many of these have been referred after an amniocentesis had been performed at another hospital where it was recognized that the patient needed intrauterine transfusion. Of 52 patients, we lost 43 babies. This represents a mortality of 82 per cent. This is an improvement over the previous nearly 100 per cent mortality. Of the 9 survivors, 7 had intrauterine transfusions and 2 had premature deliveries.

Laboratory Aid
(Dr. Antonio Scommegna)

It has been reported in the literature that estriol determinations in erythroblastosis are not as revealing as they might be in other conditions such as diabetes, toxemia or postmaturity. The reason for this is presumed to be that there is a possibility that the mechanism involved in the normal production of estriol is augmented in erythroblastotic babies. In fact, in mildly affected babies we have seen the highest values of estriols that we have recorded in our laboratory. This is perhaps related to the fact that these babies have large placentas and large livers. We know that aromatization of neutral steroids (which are the precursors of estrogens and estriol in particular) takes place in the placenta and hydroxylation in position 16, which is necessary for estriol production, takes place in the liver. The mechanism is a question of production, so to speak, and is very effective in these babies due to the large placenta and large liver.

However, once the fetus has been jeopardized, that is—the fetus is suffering or in severe danger, we see a decrease in the estriol. This has been recognized in other series as well. Notwithstanding, the value of estriol determination in erythroblastosis is still very limited. One of these cases shows when it can be useful. Although amniocentesis is a much more powerful tool in diagnosing and managing these infants, when the amniocentesis for some reason is unreliable, whether because there is contamination by meconium or by blood, estriol might be useful. In these cases, low estriol or, much more importantly, a drop in estriol can indicate fetal jeopardy and immediate delivery is sometimes indicated, as in the first case.

It is difficult to explain the low estriol in the second case. Here the outcome was good in spite of the rather low estriol noted about the twenty-ninth to thirtieth week of gestation. Most cases with low estriol excretion levels have terminated in fetal or neonatal death. However, in this case I think the intrauterine transfusion might have been instrumental in saving this baby. The estriol level went up somewhat but certainly it was always in the low range. We would have predicted fetal death if it were not for these intrauterine transfusions. The urinary estriol might help somewhat in

these cases. However, its value is secondary to the other armamentarium that we have available.

Of importance in these cases might be amniotic fluid estriol. We do not have enough data as yet, but it seems that there is a much larger decrease in the amniotic fluid estriol as compared to urinary estriol. This drop may also occur earlier. Another noteworthy feature is the pattern of conjugation of estriol in the amniotic fluid. In erythroblastotic infants this may be different from normal conjugation in that the glucosiduronate fractions appear to be decreased. However, these data still are preliminary.

Intrauterine Transfusion (Dr. Allan G. Charles)

We have performed 50 intrauterine transfusions on 34 different patients so far, of which we only have 7 survivors. This is an uncorrected fetal survival rate of only 20 per cent. However, two of the babies that were born alive and died could well count as successes. One had a very high cord hemoglobin with a high percentage of adult hemoglobin, but the baby unfortunately had congenital absence of the kidneys and therefore had no chance from the very beginning. The second baby illustrates how vulnerable we may be. This is one of the reasons we try to time our deliveries for early in the week and early in the day. This baby was born with a reasonably good hemoglobin, but developed kernicterus because the pediatricians following the baby were misinformed by the laboratory, the bilirubin being reported low. When it was discovered that there were laboratory errors, the baby already had developed kernicterus and died. Therefore, if these 2 cases were counted as technical successes, the overall survival rate would have been 27 per cent. This includes 10 cases in which there was hydrops fetalis with no hope for survival. We did these cases and have included them in our series. The hydropic babies are the easiest babies to transfuse because the large abdomen is, of course, much easier to reach with a needle. However, although many of these cases were born alive, they were very severely affected and in addition had had very difficult deliveries because of soft tissue dystocia. We have become much more selective recently and no longer transfuse hydropic fetuses. In the absence of hydrops, the overall survival rate was 38 per cent corrected or 30 per cent uncorrected. The fetal deaths due to the procedure itself, including all babies dying shortly after the procedure regardless of actual cause, totalled 4 in the 50 intrauterine transfusions, an 8.0 per cent mortality rate per transfusion. This is much lower than the average 20 per cent recorded by Bowman and Friesen in Winnipeg. It is important to realize that every time an attempt at intrauterine transfusion is made a similar risk rate exists.

We have devised a classification which categorizes patients for intrauterine transfusions in the same way cases of carcinoma of the cervix are staged. It is not quite the same to do an intrauterine transfusion on a 24 week fetus (according to Bowman and Friesen with a mortality rate per procedure of 50 per cent) as doing it on a 32 week fetus. There is a real need for a more uniform method of reporting the results based on the degree of severity or the timing of the need for transfusion. Clearly, the ear-



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lier the transfusion, the more severe the cases.

Four of our earlier losses were due to prematurity. We seem to have reduced this problem by the use of Ampicillin and isoxsuprine. We are not sure whether this is factitious, or represents an actual improvement in our technique, or is the result of the use of Ampicillin and isoxsuprine. Liley suggested that premature labor may be due to a low grade amnionitis. Although we have seen no overt infections either before or after we have used the Ampicillin, we have not had any cases of premature labor since we began to use it. We will therefore continue to use it empirically.

Avoid Error of False Reading

It is important to emphasize that the direction of change in the curves is most important. We rarely use a single amniocentesis to make a decision. We take into consideration the husband's zygosity, the previous obstetrical history and the size and change of the pertinent peak of the amniotic fluid curves. This latter avoids the error of false positive readings. High zone curves have been reported in Rh negative fetuses. The question arises as to whether this second baby is Rh positive or negative. Since the estriol and the repeated curves indicated a severely affected fetus, the fact that the baby is still Rh negative does not mean that it is indeed basically Rh negative. In all, 98 per cent of its hemoglobin was adult hemoglobin and, therefore, transfused blood. The life expectancy of transfused cells should be (since we always use fresh cells) 120 days. I think, therefore, in one month one would not expect to see the conversion to Rh positivity. This case certainly represents the acme of success in intrauterine transfusion. Actually, it represents to me the possibility that, when there is a highly successful intrauterine transfusion, the fetus can perhaps be left in utero much longer than was previously anticipated. The baby could perhaps have had another 2 weeks in utero to provide for greater maturity.

Pediatric Considerations (Dr. Paul Wu)

In the follow-up of infants who have received intrauterine blood transfusion, we in pediatrics have to reorient our thinking as to the type of infant with which we are dealing. They differ significantly in the degree of severity from that which we are used to seeing. Our assessment of these infants must be adjusted accordingly. We have to gather data in order to learn how to assess them. The first thing we are particularly concerned with in infants who have received intrauterine blood transfusion is the percentage and the type of hemoglobin that these infants have at the time of delivery. Before the era of intrauterine transfusion, estimation of the percentages of adult or fetal hemoglobin was the exception rather than the rule. After an intrauterine blood transfusion this is imperative because it does give some indication of the success of the treatment as well as other pertinent points which we will discuss shortly.

In relating the percentage of fetal hemoglobin concentration to preterm, term, or postterm infants, the gestational age rather than the birth weight should be employed. The greater validity of gestational age as an index is to be expected because replacement of hemoglobin by the adult hemoglobin is essentially a maturation process that is not of necessity connected with body growth. This is illustrated by the finding of identical hemoglobin-F concentrations in dizygotic twins. Also we find contrasting cases of low birthweight infants who have a certain percentage of hemoglobin-F and dysmature infants of the same birthweight with much higher concentrations of hemoglobin-A. Although most workers have found significant differences in the hemoglobin-F concentrations in groups of preterm, term, and post-term infants, there is a wide range of values among these infants at any particular gestational age. This prevents prediction of gestational age by using hemoglobin-F concentrations in individual infants. The best correlation is obtained when the ratio of hemoglobin-F concentration to birth weight in kilograms is charted against gestational age. A reasonably good linearity and minimal scatter is obtained and a 95 per cent confidence range of prediction can be achieved.

Hemoglobin Level Maintenance

Our data on the ratio of the hemoglobin-F in cord blood showed that the intrauterine blood transfusion had been entirely successful in the majority since the fetal:adult hemoglobin ratio was extremely low. When the percentage of hemoglobin-A is plotted

against the number of days after the last intrauterine transfusion, we see that if the infant is born within 48 hours, the percentage of hemoglobin-A, the adult type, is low. This would indicate that it takes an interval of at least 24 to 48 hours before an adequate level of hemoglobin-A is absorbed. This approach also shows that an adequate level can be maintained for a period of up to about 2 weeks. After 2 weeks there is a tendency for the hemoglobin to fall again. This suggests that, where it is necessary to repeat intrauterine blood transfusions, one should aim for about a 2 week interval rather than waiting longer. In one or two of our cases we have tended to procrastinate because of the success of the previous transfusion; in these we have encountered some trouble because we have waited too long. We saw the hemoglobin fall, apparently because of the increase in the size of the infant, the blood volume, and the production of fetal cells.

Plotting the per cent of hemoglobin-A against the number of intrauterine blood transfusions, we find that as far as the hemoglobin-A is concerned the number of exchanges does not have a very marked effect. We do find that, in those infants who have received 3 or more intrauterine blood transfusions, the hemoglobin-A is higher. We also occasionally see high hemoglobin-A after only one intrauterine blood transfusion. Therefore, it would appear that some other factor might be responsible. The percentages of adult hemoglobin appear to depend more on the total volume administered. If we can administer a volume exceeding about 150 ml. into the infant, then perhaps we can achieve a good concentration of adult hemoglobin in these infants.

Bilirubin

The next factor we are interested in is, of course, the bilirubin. Our previous experience showed that a critical level in cord blood was generally associated with a rather seriously affected infant. I was somewhat puzzled to find that in the infants who had received intrauterine blood transfusions this was no longer true. Examining the levels of serum bilirubin in the cord blood plotted against the total volume of the blood transfused, we have seen no definite correlation between the amount transfused and the cord blood concentration of bilirubin at the time of delivery. In general, a better correlation appeared to exist with total hemoglobin. When we plot the serum bilirubin against the concentration of hemoglobin present in the cord blood, we find that there is a somewhat linear relationship. A word of caution is in order here. We may be dealing with infants who have quite a high bilirubin as a result of blood received. We do not know, for instance, what degree of hemolysis can occur in the peritoneal cavity. Perhaps we should aim merely at limiting transfusions to a particular volume sufficient to maintain the infant until the time of delivery rather than to overload with a larger amount. This is just a suggestion based on preliminary data.

There is no apparent correlation between the serum bilirubin and the percentage of hemoglobin-A. We have found that one of the features of those infants who have received a successful intrauterine blood transfusion is that their blood is generally the same group as the donor, and is Rh negative and Coombs negative. As to outcome, the group showing high absorption of transfused blood seems to have done much better. Incidentally, the percentage of hemoglobin at the time of birth has no bearing on outcome. In many, the hemoglobin levels were well in the hydropic range. It would appear that what has kept these babies alive was the donor blood. We find that there was a higher mortality among infants showing vestiges of their own blood type (mixed). Here again in most of these infants the hemoglobin is in the range where one would expect them to be hydropic. In fact several were hydropic infants. Finally, in the group that had their own blood grouping we find that the mortality is somewhat higher. In all, 7 of our 14 liveborn infants survived. This does indicate quite good results and are comparable with those that have been reported.

Prevention (Dr. Emanual A. Friedman)

Attempts to prevent Rh sensitization date back almost to the discovery of the relationship between the Rh factor and erythroblastosis fetalis in 1940. The attempts fall into three broad areas: (1) preventing initial sensitization of the mother by protecting the placental integrity, avoiding intrauterine manipulation and trauma, thus ostensibly to prevent the offending fetal red

cells from entering the maternal circulation; (2) blocking the sensitization by injecting antibody to neutralize the fetal cells that have gained entrance to the maternal circulation; (3) neutralizing or inactivating the circulating antibody present in maternal circulation before significant amounts cross to the fetus. Efforts along the last avenue included the unsuccessful use of Rh hapten, cortisol, and ethylene disulfonate; and more recently (and somewhat more successfully) by various ribonucleic acid derivatives (adenylic acid, uridylic acid, cytidylic acid, and cytidine hemisulfate), unnatural sugars (l-glucose, l-mannose, d-gulose), and sugar-amines (glucosamine and galactosamine). These latter have shown some promising preliminary in vitro and animal results in inhibiting the formation of complete and incomplete Rh antibodies. The most encouraging and hopeful application, however, appears to be in the area of blocking sensitization by use of high titer antibody.

The history of development of this method is quite interesting, two independent groups having arrived at the same place almost simultaneously by two different routes. As far back as 1943, Levine noted a negative relationship between ABO-incompatibility and Rh sensitization. In ABO-incompatible situations (between mother and baby), a certain degree of protection seems to exist for the infant. This concept formed the basis for the investigation designed by Finn and Clarke in Liverpool. It was felt that naturally occurring ABO antibodies somehow affected the foreign red cells from the fetus in such a way as to prevent the Rh antigen from expressing itself to the extent of causing sensitization. In the course of their work, they found transplacental fetal cell leakage, using the Kleihauer-Betke method of staining fetal red cells (acid elution), and set about to devise some means of eliminating these foreign red cells from the mother's circulation. It occurred to Finn that artificially injected anti-Rh antibody might coat the Rh positive fetal cells so as to inactivate their antigenicity and also to clear them from the mother's circulation rapidly before they could immunize. The logical step then was to administer passive antibody as a means of preventing hemolytic disease of the newborn.

At the same time, Freda and Gorman in New York arrived at the same method, on the basis of other theoretical considerations. Theobald Smith first recorded the phenomenon of immunity inhibition in 1909, when he noted that diphtheria toxin injected with an excess of antitoxin was no longer antigenic. This has been confirmed many times over since then. The specific antibody injected passively, either with its antigen or separately, prevents active immunization. The principle briefly stated is that passive immunity strongly suppresses active immunity. Freda and Gorman put this principle to use in 1960 and initiated a program to determine whether initial immunization of Rh negative mothers could be prevented by the passive administration of Rh antibody immediately after childbirth. Simultaneously and independently, Finn and Clarke began their experimental work along the same lines.

The materials used at the outset were somewhat different, Freda using high titer anti-D gamma-globulin; Finn using immune plasma. The single risk that had been feared most, namely the phenomenon of enhancement, rather than suppression of immunity by passive antibodies, was obtained by the Liverpool group using immune plasma containing the large (19S) saline gamma M anti-Rh antibody. Subsequent use of the purer gamma G (7S) anti-Rh antibody gave no evidence of any degree of immunological enhancement in either Rh negative male volunteers or recently pregnant mothers. It is still possible that mothers may develop isoimmunization to antigens on the injected gamma-globulin molecules, but it is doubted that this would have clinical significance. The anti-Rh gamma-globulin is prepared in the same way that currently available gamma-globulin for protection say against measles is made, namely by low temperature alcohol-fractionation procedures starting with very high titered specific anti-D serum, preferably from type AB, Rh negative donors where it is possible to obtain these. This is a most satisfactory preparation because it does not carry risk of hepatitis. The titer of material used is around 1:260,000. Injection of 5 ml. produces artificial titers of antibody up to 1:128.

Finn found that when Rh positive red cells labeled with radioactive chromium were injected into Rh negative male volunteers, and the recipients were given the

potent anti-D serum, the injected cells disappeared rapidly, about 50 per cent in two days. When 5 ml. of the high titer incomplete anti-D gamma-globulin was given intramuscularly, Rh positive fetal cells could be rapidly removed from the circulation. Starting with Rh negative male volunteers who were challenged with injections of Rh positive red blood cells, Freda and Gorman progressed to studies in the postpartum patient, beginning in 1964 to administer the Rh immunoglobulin preparation to all postpartum mothers at risk, namely those Rh negative mothers delivered of Rh positive ABO-compatible infants in whom there was no evidence of active immunization found either during that pregnancy, at delivery, or within the three day period immediately following delivery. This is somewhat at variance with the group selected by Finn and Clarke, who only administered Rh immunoglobulin to "high risk" patients in whom they found a significant number of fetal cells in the maternal circulation (by the Kleihauer method).

Clinical trials to date have been reported on 329 patients at risk who were completely protected by the immunoglobulin preparation as compared with 337 control mothers, 46 of whom became sensitized subsequently (13.6 per cent). These were all first pregnancy results. A small number have been followed through a second pregnancy: 31 passively immunized mothers were completely protected as contrasted with 27 control mothers, among whom 11 became sensitized (40.7 per cent) and subsequently delivered infants with hemolytic disease.

It appears that at least six months must elapse before the passive antibody completely disappears. As long as any passive antibody persists in a given individual, it is impossible to determine whether or not active antibody production has taken place. More significantly, the best check on the efficacy of protection is the outcome of subsequent pregnancies with Rh positive fetuses. This would represent a more critical biological test of immunization than postpartum antibody screening because such subsequent pregnancies tend to provoke a strong secondary immune response. Moreover, prevention of clinical hemolytic disease is the real proof of effectiveness. It is very encouraging to see the accumulated data being gathered from various centers to indicate that Rh immunoglobin is effective in preventing clinical hemolytic disease of the newborn and has the ability to suppress anti-Rh antibody in the postpartum period. If this trend continues, we may be witnessing the beginning of a marked shift in emphasis from management of erythroblastotic babies to prevention of maternal immunization.

TEST FOR LEAD

Adequate multiple sampling of the urine is the only method, in practice, that will certainly provide the information required for the purpose of depicting the extent of the occupational hazard of an individual due to lead, if indeed one must depend upon the urine for this purpose. On the other hand, the blood is not subject to any very considerable diurnal physiological variation, with respect to its lead content, so that the accurate analysis of one certainly uncontaminated specimen of blood is more useful in the estimation of the significance of the occupational exposure to lead than is any other procedure. One precise analytical result on the blood of an individual is worth several analytical results (of equal precision) on the urine of the same individual in estimating the safety or danger of his regular occupational exposure to lead. In addition, the upper limit of safety, in relation to the concentration of lead in the blood, is defined sharply by precise analytical procedure, at 80 micrograms per 100 Gm. of whole blood, while the corresponding limit in the urine must *always* be expressed as a range of values approximating 0.15 to 0.24 mg. per liter. Question Clinic. Jl. Occupational Med. (Apr.) 1968, *10*:4, 201-202, (Question: Accuracy of Atomic Absorption Spectroscopy in Urine Analysis for Lead, answered by Robert A. Kehoe.)



THE DOCTOR'S LIBRARY

NEPHROLOGY—Volumes I and II: Jean Hamburger, G. Richet, J. Crosnier, J. L. Funck-Brentano, B. Antoine, H. Ducrot, J. P. Mery, and H. deMontera. With the collaboration of: P. Royer. Translated by: Anthony Walsh, F.R.C.S.I. W. B. Saunders Co., 1968 Illustrated. 1312 pages. $50.00 the set.

This two volume treatise is both a textbook of nephrology and a compilation of the views and experience of the most eminent group of nephrologists in France. The work, which was written by some 17 workers, headed by Professor Jean Hamburger, was first published in French in 1966. The 1968 American edition, translated by the urologist Anthony Walsh of Dublin, has been revised and in some places rewritten to bring it up to date. That there was need for such changes after so short a time is a reflection of the extraordinary interest and activity in the subject of nephrology.

The subject matter covers virtually the whole field of nephrology, which the authors define as the study of the kidney in health and disease. The work, which consists of 58 chapters, is divided into 12 parts, including the anatomy and physiology of the kidneys; symptomatology and renal function tests; major renal syndromes; functional renal disorders; organic nephropathies; sundry pathological conditions of the kidney (24 chapters); malformations of the kidney and urinary tract; nephrolithiasis and nephrocalcinosis; renal tuberculosis; tumors of the kidney; renal vessel pathology, and major therapeutic procedures.

With such a vast range of subject matter, it is not surprising that some aspects are dealt with in more detail, and perhaps more authoritatively, than others. Throughout the work, emphasis is placed on current knowledge of renal pathophysiology, which of course is the area from which so much of our improved understanding of kidney disease has come, particularly since the advent of percutaneous renal biopsy, and the application of electron microscopy and immunofluorescent techniques to biopsies.

One criticism to be made of this great work is that in areas of persisting contention, usually only one view of the problem is presented. To some extent, this deficiency is mitigated by a good bibliography after each chapter.

The two books, which are beautifully produced in the manner one expects of the W.B. Saunders Company, are an outstanding contribution to the subject, and will be referred to by all those seriously interested in nephrology.

Peter B. Herdson, M.B.,Ch.B.,Ph.D.

RADIOLOGICAL STUDIES OF THE GRAVID UTERUS. Paul A. Bishop, M.D. Harper and Row, 1965. 279 pages, $14.50.

Radiological Studies of the Gravid Uterus is unique as a radiology text in that it deals specifically with fetal growth and development and pathology. The author has successfully prepared a book that is valuable to both radiologist and obstetrician and emphasizes the need for cooperation of the two in planning the radiologic consultation. The material presented is primarily gathered from the Department of Radiology, Pennsylvania Hospital, where Dr. Bishop was formerly Director.

The illustrations are of a quality that require little supplementary text and comprehensive enough that few radiology departments have an equivalent accessible source of reference cases. The chapter on erythroblastosis and fetal hydrops is especially interesting. The subject of pelvimetry is excluded.

The book is recommended to both obstetricians and radiologists.

William N. Brand, M.D.



Out Of The Detail Man's Satchel

By Joseph P. Renald/Chicago

The synthetic pharmaceuticals industry in America at the close of the First World War was in its early years. Pharmacists still compounded most of the medicines prescribed by physicians. Proprietary drugs were relatively few in number and the heyday of pharmaceutical advertising was about to begin. The detail man, calling on physicians in large cities and small towns, was in a particularly advantageous position to observe medical practice at a stage where it was far different from that of today.

In the spring of 1920 this writer was appointed by Herman A. Metz, President of the H. A. Metz Laboratories, Inc., to be the firm's representative in the Northern Midwest. The territory extended from Alton to Duluth, Minn., and from Omaha to Northern Indiana, with Chicago as headquarters. As general representative, duties included both detail and sales work. This necessitated visiting all of the medical schools in the area, the principal hospitals and clinics, and the health officers, as well as many of the leading medical specialists.

The company was a well-established pharmaceutical house originally importing German drugs but at this time beginning to manufacture in the United States. The drugs produced were very important at the time and included the Salvarsans (arsphenamines), Novocaine (procain), Pyramidon (amidopyrin), Holocaine (an eye anesthetic), and a variety of other special products.

It was my duty, not only to introduce and promote products, but also to advise and instruct physicians and dentists in their proper use.

Inasmuch as I was not a doctor, this imposed a considerable responsibility, but I had at my disposal the firm's specially trained chemists and physicians for consultation. I was also free to obtain assistance from a small group of doctors in the area who were on the payroll of our company, and they performed a very valuable service. They were honest, reliable, and well informed. They stood high in their professions and had complete freedom of opinion without pressure or prejudice.

From the detail man's point of view, it seemed that the venereal diseases played a very large part in the office practice of the physicians at that time. This impression may have been weighed by the importance of the anti-luetic drugs we produced.

Practitioners Instructed

Many physicians who wished to treat their syphilitic patients with Salvarsan hesitated to go through the required procedure of converting the basic material to a sodium salt. This was essential since otherwise the drug could be fatal. The procedure of conversion consisted of titrating with a solution of sodium hydroxide. To avoid this task and the responsibility imposed in it, these doctors preferred to send their patients to one of the medical laboratories whose technicians were trained in this procedure. In a similar fashion, prior to the availability of cartridges or ampules, doctors and dentists had to prepare their own solutions of Novocaine and epinephrine. It was among my duties to instruct the practitioners in these preparations and in the techniques of their administration. Familiarity was also required with such techniques as the Swift-Ellis intraspinal administration of Neosalvarsan, and how to cope with the immediate reactions such as shock from too rapid administration, the Herxheimer reaction, arsenical dermatitis, and other unfavorable developments.

Through continual contacts with the medical profession, a general, broad view of the drugs in use, many of which have since been discontinued, was obtained. Benzyl benzoate was regarded as virtually a specific in asthmatic spasms. Silver nucleinate and proteinate colloids were very widely employed in treating the mucous membranes of the nose, throat and eyes. Gonorrhea was almost always treated with the silver salts. Sodium cacodylate, an arsenical, was frequently used in the early 1920's for treating syphilis, having been advocated by no less prominent a physician than Dr. John B. Murphy. Lactobacilli, such as the b. Bulgaricus, were in very wide use for intestinal disturbances. Certain organic mercurials originally introduced as anti-luetics later came into wide use as diuretics. Antibiotics did not begin to dominate the field until the early and middle 1940's.

Novocaine Introduced

Pyramidon, despite its very extensive employment, all but disappeared when it was occasionally found to cause agranulocytosis. Anesthetics such as methyl-, and ethylbromides, benzyl alcohol, and stovaine have been supplanted by other agents. Novocaine, which was introduced in 1909 on the other hand, has persisted with even wider use in infiltration, regional block and spinal anesthesia. The last mentioned technique owed its very wide popularity to the introduction of Pitkin's Spinocain and the Labat technique of using Novocaine crystals. The term "anesthesiology" came into common usage in the early 1930's and its methods have expanded far beyond those in use at the time. One surgeon is recalled who claimed to have used Spinocaine in some 2500 operations, but did not publish his satisfactory experiences lest his name become associated with commercial exploitation of the drug. Avertin (tribromethanol) was brought into this country from Germany, but never attained wide usage.



Joseph P. Renald was the first laboratory assistant to Dr. Casimir Funk, a leading discoverer of vitamins. Mr. Renald worked many years with Dr. Funk and eventually became an independent chemist. He served over 20 years as a manufacturers representative for medical implements and products.

A general attack against venereal diseases was launched in the early years of the second decade. Syphilis and gonorrhea had multiplied at a rapid rate as an aftermath of World War I. The United States Public Health Service, through its Surgeon-General, Dr. Parran, sponsored an eradication campaign by the Illinois State and Municipal Health Departments. Dr. Herman Bundeson, Chicago's Health Commissioner, established several large venereal disease clinics in the city which also spurred the activities of the Illinois Social Hygiene League, an independent organization to combat these illnesses. Prominent citizens were induced to underwrite a greatly advertised V.D. clinic known as the Public Health Institute, under the direction of Dr. J. G. Berkowitz. Because advertising was regarded as unethical, organized medicine declared that staff doctors of this institution were to be dropped from the American Medical Association unless they withdrew from the Institute.

Dr. Bundeson had ordained that prostitutes arrested and found to have V. D. were to be incarcerated in a special isolated ward at the Municipal Contagious Disease Hospital until they were rendered non-infective. The "ladies of the night" received their medical attention from Dr. Goldye Hoffman. A V.D. clinic was also established at the Iroquois Memorial Hospital, then located at 23 North Market Street with Dr. Hugo Betz in charge. Dr. Betz also maintained a private general practice in the basement of a house on Garfield Boulevard.

The Public Health Institute was organized for the care of low income patients and the fees, including diagnostic tests, were within their reach. The Institute also served as an experimental station for an arsenical preparation (tryparsamide) which had been especially developed for neurosyphilis. Some ten years later the Institute merged with the Illinois Social Hygiene League, with paying patients going to the Institute and the non-paying ones to the League Clinic.

Through Dr. Bundeson I met Dr. Lee Alexander Stone who bore the Health De-

partment's title of "Chief of the Public Hospitals." He, in turn, introduced me to the picturesque personality, Dr. Ben Reitman, who was already known as the whilom paramour and manager of the anarchist Emma Goldman. He was at that time urologist at the House of Correction and invited me to visit the clinic at the Bridewell. We met at 5:30 a.m. at a nearby restaurant and from there proceeded to his institution. The demonstration was somewhat ghastly. Neosalvarsan was put into solution in small fruit jars because the prison had no other glassware. Sterility and purity of the distilled water were very sketchy. It is not surprising that there were many immediate reactions.

Dr. Reitman and I became very close friends and from him I learned much about the leftist political movements of the World War I years. Also through him I met Dr. William A. Evans, Health Columnist of the Chicago Tribune. Dr. Evans was not only a reputed public health authority, (he had been Health Commissioner of Chicago and also Professor of Public Health at Northwestern University Medical School), but was also a well-informed Civil War buff, a shared hobby. He had written a medical biography of Mary Todd Lincoln. Drs. Evans and Reitman were very close friends and used to take long swims together such as from Belmont Harbor to the foot of Navy Pier until the authorities put a stop to these aging enthusiasts.

Vivisection Discussions

On one occasion Dr. Evans invited me to accompany him to a meeting of the Illinois State Legislature Committee at the City Hall to hear arguments for and against an antivivisection law that had been introduced in Springfield. As we entered the chamber, the renowned Professor of Physiology at the University of Chicago, the colorful Dr. A. J. Carlson, was berating the antivivisectionists who had charged that all persons who performed experiments on animals were unjustifiably cruel. Carlson, in reply, recalled that he had been President Hoover's special consultant on the project of feeding the starving children in Belgium and Russia after the War and that he considered it an insult to be charged with cruelty. Dr. Evans, sitting next to me, fidgeted and muttered, "I wish Carlson would sit down." The reason became apparent when several invited veterinarians presented evidence that vivisection benefited animals as well as humans and that the inhumanity was on the part of those who would see the animals suffer from diseases of which they could be cured. Dr. Evans had been instrumental in organizing this flank movement against the antivivisectionists. The bill did not pass that year.

All in all, early experiences from the early 1920's through the late 1930's, a few of which have been mentioned here, were rich and rewarding. I witnessed the introduction and the disappearance of many drugs that were considered important. Some soon became limited in use, others became monuments. Novocaine is the exception that still survives as the most widely used of all local anesthetic agents.

In my work I met many fine members of the healing professions. Numerous physicians, surgeons and dentists became and still are warm friends. In these later years, those who are still here exchange memories like these recorded and make them seem as if they occurred but yesterday. I was a confidant of some of these professional practitioners, listened to the stories of their experiences which were otherwise not disclosed. Some were humorous and some were tragic, but they gave my quasi-medical status a perspective I could not otherwise have had as a layman.

The 166 Veterans Administration hospitals are affiliated with 76 of the nation's 94 medical schools in a partnership that provides better medical care for veterans and helps to train half the nation's new doctors in 20 fields of medicine.

The Veterans Administration plans to provide intensive care units for critically ill patients in more VA hospitals. This includes special facilities in private rooms for cardiac patients.

Seven Day Utilization Of Our Hospitals

By Frederick Stenn, M.D./Chicago

The hospital structure is strained by the great demands imposed on it not only by a teeming population, and by improved medical services, but by Medicare, by preventive medicine and by prosperity generally. The critical shortage of hospital beds demands a solution beyond the use of restrictive methods. The policing of admissions, curtailing the duration of stay and accelerating the discharge of patients has helped some but not enough. A promising movement initiated some ten years ago lies in the improvement of bed utilization by the extension of the ancillary or integral services through Saturday and Sunday of each week.

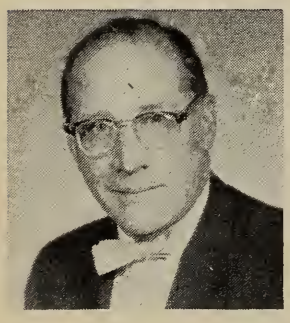
Every member of the medical team is painfully aware of the tempo of hospital service. Bed and laboratory utilization follows a feast and famine pattern, a peak and valley work-load: a bottleneck on Sunday night, a deluge on Monday, a rush on Tuesday, a steady flow on Wednesday and Thursday, a slackening on Friday, a trickle on Saturday morning, and a dead-stop on Saturday afternoon and all day Sunday. This fluctuation is seen most with surgical patients, less with medical and least with psychiatric, pediatric and obstetrical patients. This inequality in the daily use of beds and services has proven to be inefficient, wasteful, and uneconomical. Why must there be two waiting lists: the outpatient list composed of those waiting one day up to a week to be admitted, and the inpatient list of those waiting days until Monday when the laboratory, awakened from its week-end slumber, begins to function for elective studies. Why must a patient's release be delayed so that a blood sugar or a PAP smear might be done on Monday morning? Is watching time essential to the conduct of the modern hospital? What is so inviolable about Saturday and Sunday? Why must x-rays of the gastro-intestinal tract beginning on Monday finish before Friday? Why must the stroke patient requiring physiotherapy twice daily be obliged to omit such service on Sunday?

The ancillary or integral services and facilities—X-ray, chemistry laboratory, dietetic, pharmacy, heart station, business, laundry, housekeeping and engineering—are valued, in most instances, in many millions of dollars; yet they are put to little use for one and a half to two days of each week, 6 days of each month, and 78 days of each year. This is bad business, and worse medicine.

Sickness respects no calendar, no day of the week. A man with a coronary thrombosis deserves as good care on Sunday as he gets on Tuesday when all services are functioning. What physician does not have an added worry for the patient admitted as an emergency on Saturday night or Sunday with diabetic coma, bleeding peptic ulcer or acute abdominal condition? Why must the physician who on Friday submits to the microbiology laboratory sputum from his gravely ill pneumonia patient wait for a report of polymyxin-sensitive pseudomonas culture until Monday night when his patient has died? Laboratory care is bound hand and foot with bed-side care: neglect the one and we fail the other.

Hospital Example Cited

The Cooper Hospital of Camden, N. J., with a bed capacity of 700 and under the direction of Robert Garrett, Jr., has set a fine example in the resolution of the bed shortage problem. In January 1963 it initiated a 6-day work week: so successful was



Frederick Stenn, M.D., is a practicing internist with offices in Chicago. He is a graduate of the University of Chicago Medical School and served his internship at Evanston Hospital. He is interested in the History of Medicine.

this experience that in January 1964 it began a 7-day week which operates effectively at present. All integral services are in operation every day of the week. The operating rooms are functioning in full force, 15 of the hospital surgeons operating regularly on Saturdays and Sundays. The employees work 40 hours a week and have staggered hours Saturday and Sunday once monthly. The change has required the addition of 10 new employees to a complement of 1,040 employees. Their salary has increased ten cents hourly. The ratio of employees to patients in 1961 (5-day week) was 2.22: in 1964 (7-day week) 1.89. The average census has increased by 6% or 38 patients daily, being 90% in 1961, 91% in 1962 and 96% in 1963. In 1964 the change to a 6-day week resulted in reducing the average stay by ½ day. In one year the hospital admitted 981 more patients, the equivalent of 30 hospital beds. Two months after the 6-day operation was put into effect the Cooper Hospital operated in the black. Its income increased $4,300.00 daily above that of 1961, and the yearly income in 1963 exceeded that of 1961 by $500,000. This change has eliminated the need for new hospital construction. The staff morale has improved and a professional pride has been created. No longer was it necessary to add extra staff to meet peak loads.

The change-over was at first met with the usual resistance offered any new idea but the benefits provided by an even census, the sharing in providing efficient services at all times of the week, the financial incentives and long vacations were acclaimed by the hospital employees and physicians alike.

This plan of week-end hospital service has been adopted by other institutions as well. The Veterans Hospital of Coral Gables, Fla. and the Tunica County Hospital of Tunica, Miss., have been operating satisfactorily for a number of years. The Albany Medical Center adopted the 6-day week in 1964 and has thereby reduced the hospital stay appreciably. The Jewish Hospital of Cincinnati admitted 10 to 20 more patients each week as a result of the change. The Pontiac General Hospital of Pontiac, Mich., is now initiating a 7-day hospital program.

The advantages of the 7-day week as experienced by these hospitals consist of:

1. Prompt diagnostic and therapeutic service reducing delay.
2. Efficient use of hospital beds and equipment.
3. Briefer hospital stay.
4. Fewer beds needed for care of the same number of patients over the year.
5. Lower capital investment for patient.
6. Spread of costs over a large number of patients.
7. Lower cost for hospitalized patients.
8. Reduced human suffering because of rapid service.

Objections to the program have been made by physicians who fear lowered standards of care and service because of the scarcity of adequately trained personnel. Practical experience however, shows this fear as invalid. Some directors of the ancillary services have been cautious in undertaking week-end responsibilities, but assistants and residents taking their places have done a better job than anticipated.

Natural Extension of Services

The 7-day hospital service is a natural extension of our present continuous nursing and emergency departments. Like other community services, water, sanitation, gas, electricity, fire, police, ambulance, transportation and food supply, the hospital has a necessary, around the clock, every day of the week function.

Physicians and hospital administrators can now take a hard look at our time-worn hospital tradition, and discover the 5½ day week out of step with the rapid strides of modern hospital needs.

"And, behold there was a man which had his hand withered, and they asked Him saying, 'Is it lawful to heal on the Sabbath days?' that they might accuse Him; and He said unto them, 'What man shall there be among you, that shall have one sheep, and if it fall into a pit on the Sabbath day, will he not lay hold on it, and lift it out? How much then is a man better than a sheep? Wherefore it is lawful to do well on the Sabbath days'." (New Testament, Matt. XII 10-12. Luke VI, 1-9.)

References

1. Carros, D. H.: The Seven Day Hospital: Study Shows Benefits, Hospital Topics. 45:49, Feb. 1967.
2. Editorial: Extension of Hospital Services, The Seven Day Week, Currents in Hospital Administration, March-April 1965. Vol. 9, No. 2.

(Continued on page 106)



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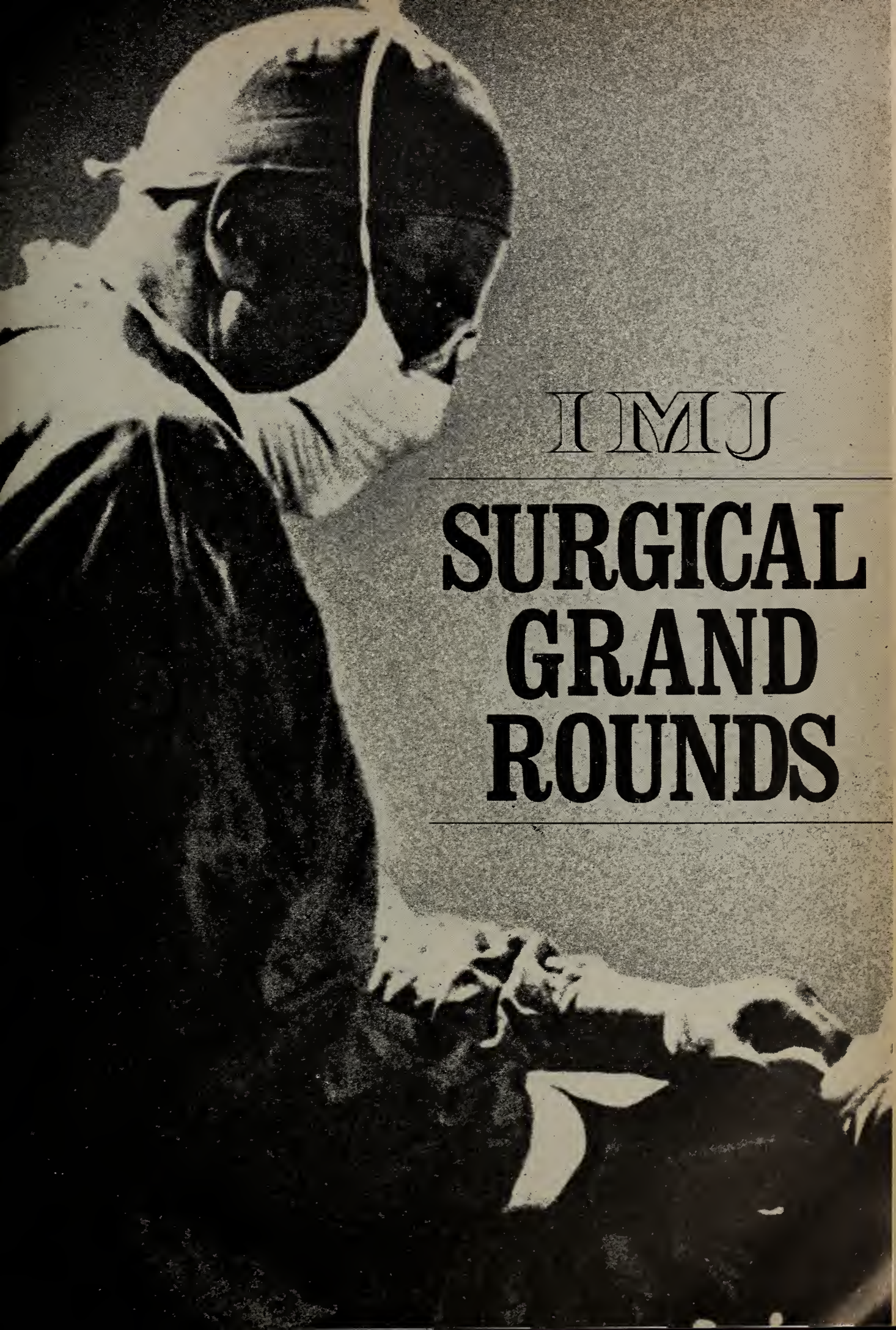
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Establishes an environmental pattern of every day living which can be emulated by all in his community.

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IMJ

SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on October 21, 1967.

Abscess of Lung

Case Presentation:

Dr. John Beal: The first patient this morning had an interesting lung problem. A patient of Dr. Shields, it will be presented by Dr. Watts.

Dr. David Watts: A 55 year old Negro man was admitted to the Veterans Administration Research Hospital in May, 1967. He complained of severe cough, productive of blood and of yellow sputum amounting to about one cupful per day. He also had chills, sweats and fever as high as 104°F. Chest pain was absent. He was a heavy smoker, two packs of cigarettes per day, and had a chronic cough for many years. Two months before his admission a chest x-ray elsewhere was considered normal. Physical examination was unremarkable, White blood cell count was 11,000 with a shift to the left. Urinalysis was normal. Sputum cultures yielded gram positive diplococci sensitive to penicillin. Skin tests were negative except for a positive P.P.D. Bronchoscopy revealed hyperemic mucosa without evidence of tumor or foreign body. Six sputum smears were negative for tumor cells and acid fast organisms. Penicillin therapy was instituted and there was prompt resolution of his fever and clearing of his clinical symptomatology. A rapid decrease in size of the lung infiltrate occurred. Pulmonary function studies were compatible with mild to moderate obstructive emphysema and a residual opacity persisted in the left lower lung field. The patient was discharged to take oral penicillin. He was seen as an outpatient at irregular intervals with persistence of the lung lesion.

In September he was admitted for the second time with a gunshot wound of his right great toe. He reported a persistent cough with minimal sputum production. Physical examination at this time was essentially negative. Hemogram and urinalysis were normal, and sputum culture grew out only normal flora. Sputum cytology was negative for tumor cell. Acid fast organisms were not found. The electrocardiographic report was that a right bundle branch block, unchanged on repeated tracing, was present. Bronchoscopy revealed hyperemia of the left bronchial tree without obstruction or tumor. Pulmonary function studies demonstrated that his maximal breathing capacity was 61 liters or 53 per cent of the predicted value. Vital capacity was 53 per cent and the residual volume was 66 per cent of normal, or 2,895 ml.

Dr. Hirsch Handmaker: The first chest films taken in May, 1967 show a left lower lobe density best seen in lateral projection (Fig. 1). The infiltrate is homogeneous,

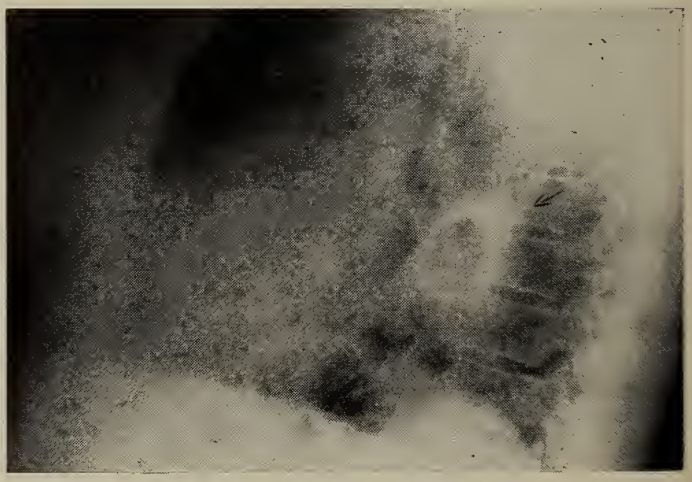


Fig. 1.: Lateral chest film demonstrated cavity in May, 1967.

not peripheral, and has a central core of excavation or cavity. It appears to lie just below the fissure but does not cross it. Following treatment the mass appears smaller on subsequent films, and the cavitation is less obvious. The October 1967 films demonstrate persistence of the density without definite cavitation (Fig. 2). Barium swal-

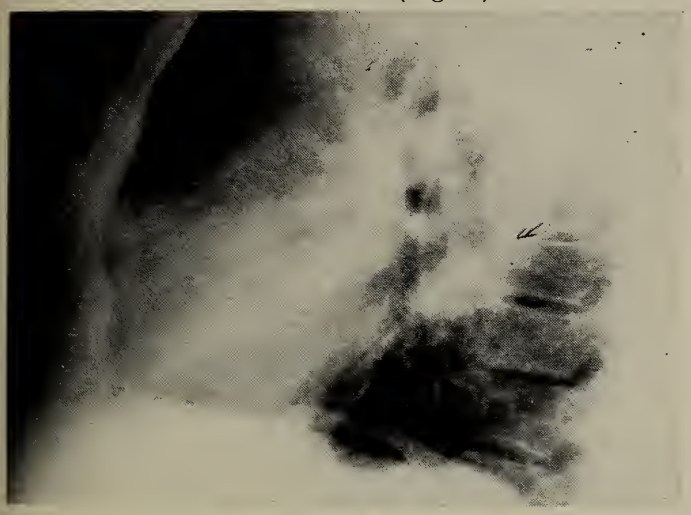


Fig. 2.: Following treatment, the mass was smaller but still present in October, 1967.

low at that time revealed neither esophagea deviation nor extrinsic pressure from mediastinal nodes. Laminograms confirmed the poorly circumscribed mass with a cavity within it. The fissure did appear traversed, and the periphery was shaggy. Central excavation favors benign abscess as the etiology, as does the course radiographically. This was our preoperative impression. Its improper location statistically (75 per cent of abscesses will be right-sided in location) and the irregular margins make the exclusion of malignancy impossible, however.

Dr. Thomas Shields: When this patient was seen originally at the V.A. the discussion centered around whether or not this was truly an inflammatory process or whether it was a neoplastic process with an inflammatory component. We were more inclined on the Surgical Service to consider this to be most likely a tumor originally because of its location in the anterobasar portion of the left lower lobe. However, the initial response to antibiotic therapy was good, and this gave the medical people enough confidence so that they felt assured in discharging him and following him as an outpatient. Unfortunately he was somewhat negligent in his return to the clinic and it was only because of the gunshot wound that he did return. Because of the persistence of the mass, in fact in the opinion of some it had increased in size, resection was planned. Bronchoscopy was repeated and was essentially normal and no contraindications to resection were present. The operative procedure went quite well. The mass was in the lower lobe and was adjacent to the fissure but did not cross it, though there were inflammatory adhesions across it to the lingula. However, because of the patient's course and his relatively poor pulmonary function, we elected to do the lobe and wedge out the area of involvement. If a frozen section of the mass did show it to be tumor additional removal would have been considered. Dr. Sherrick has the gross specimen that we removed.

Dr. Joseph Sherrick: The specimen consisted of the lower lobe of the left lung. The pleural surface showed a few fibrous adhesions. Consistency was increased, and on section there was a 3 cm. cavity connecting with a bronchus and surrounded by firm anthracotic lung tissue. The sections (Fig. 3) show the lining of the cavity,

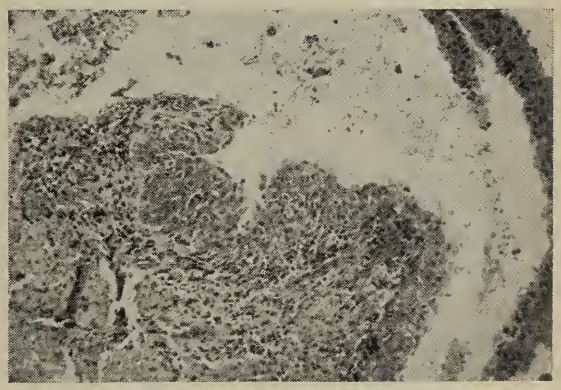


Fig. 3.: Section through the wall of the lung abscess demonstrates the presence of stratified squamous epithelium.

which is composed partly of respiratory epithelium and partly of stratified squamous epithelium. This is an example of squamous metaplasia in response to long-continued inflammation. The surrounding lung showed scarring with increased fibrous connective tissue and lymphoid follicles.

Dr. Thomas Shields: This patient's postoperative course was uneventful and he had no problem whatsoever as far as the pulmonary procedure went. During his hospital stay the metalic fragment was removed from his foot.

Lung abscesses in the past were extreme-

ly lethal problems. Well over 50 per cent of the patients succumbed to the infection before discovery of antibiotics. The thoracic surgeon was literally called upon to rescue the patient from a sinking ship with closed drainage of the chest and pneumonostomy to drain the lung abscess. Fortunately for us this surgical indication is practically never seen anymore, and the treatment of abscesses per se is medical. About 80 per cent of the patients will respond quite successfully to adequate medical management. Only the remaining 20 per cent or so will require surgical intervention which, as the rule, is a resection, segmentectomy, lobectomy, or pneumonectomy as indicated by the topographic extent of the disease. This type of surgery has two serious potential postoperative complications seen with a higher frequency than in other thoracic surgical patients. One is bronchopleural fistula and the other is empyema. With antibiotics, postural drainage, aerosol therapy these have become lessened in frequency.

The important thing in considering a lung abscess is to determine its underlying etiology. The most important, of course, is to rule out the presence of carcinoma. Well over 50 per cent of patients with lung abscesses over the age of 50 have carcinoma as the underlying cause. This is why it is paramount that a specific set of diagnostic procedures be carried out, bronchoscopy, cytologic examinations, and as indicated, bronchography in evaluating such patients. The other common cause of lung abscess is due to aspiration of a foreign body. The specific locations of aspiration abscess are due to the bronchial topography, and they are most often on the right in the superior segment of the lower lobe or in the axillary sub-segment of the upper lobe. You do not see aspiration abscesses in the middle lobe. We do see a number of abscesses here but the etiology is different. It is just common sense that when a patient is unconscious and in the prone position if he regurgitates or vomits from one cause or another the material is going to run out of his mouth. It is not going to be aspirated down into his tracheal bronchial tree in this position in contrast to an unconscious patient lying on his back or his side. So whenever you have had more than enough to drink, be sure you lie on your belly!

The other abscesses that one must consider are the specific ones of tuberculosis, histoplasmosis, coccidiomycosis, and others of the fungal origin. Hydatid cysts of parasitic origin may become infected. The mechanical cysts such as acquired cysts of bullae and blebs may become infected. Bronchogenic cysts may become infected and present as an abscess. Sequestered lungs likewise may become infected. As a result there is a large number of underlying pathologic conditions, but by and large most lung abscesses are either the result of tumor or aspiration. We have had one other patient recently of a typical aspiration lung abscess. Dr. Handmaker might like to show the films. This patient is receiving intensive antibody care and I hope this is an acute enough process that with a period of time he will respond. To judge the response of a patient under medical care the patient clinically should become afebrile, the white count should revert to normal, sputum production should become lessened, the abscess empty out, the walls become thinner and gradually the abscess cavity itself should disappear.

Dr. Hirsch Handmaker: This patient's diagnosis roentgenographically is more certainly that of lung abscess (Fig. 4). It is a

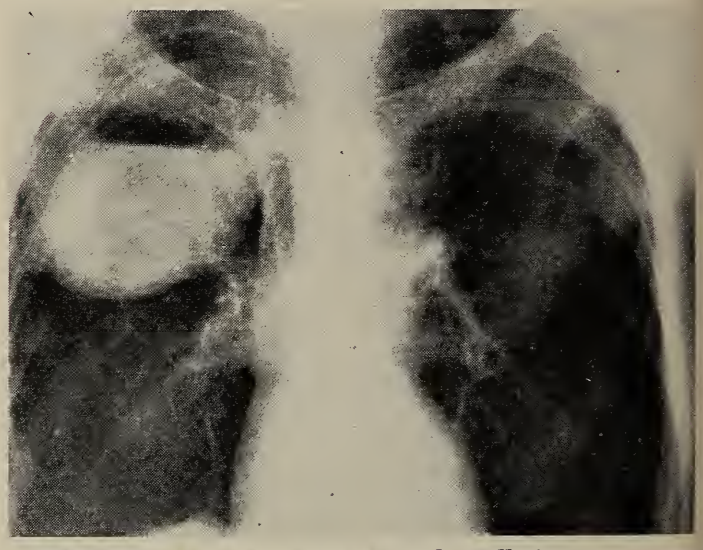


Fig. 4.: Large cavity with a smooth, well circumscribed border contains an air-fluid level.

well circumscribed mass with a very regular central cavity, smooth edge, and contains an air-fluid level. The mass is peripheral and in the right lower lobe. These findings are very typical and make him ideal for comparison with the previous patient, obviously a more difficult diagnostic problem. When cavitation appears ec-

(Continued on page 104)

A Case Of Post-Pericardiotomy Syndrome Pathogenical Consideration

By Emanuel J. Cohen, M.D., and Joseph R. Nora, M.D./Chicago

The Clinical picture of the post-pericardiotomy syndrome as it was decribed by Ito, Engle and Goldberg P.H.[6,3] and of the similar illness, the post-myocardial syndrome described by Dressler and co-workers is well known.

The post-pericardiotomy syndrome had originally been called post-commissurotomy syndrome and was first described in 1953.[7]

In some cases the clinical entity is not so complete as in the original description: this is especially true in the post-myocardial infarction syndrome in which the main complaint may be anginal pain, as we had observed in some cases. Also well known is the left shoulder (arthralgia) syndrome following myocardial infarction. The pathogenesis of these syndromes is unclear and possible knowledge of all the various clinical features in addition to the classical picture is important to better understand the pathogenesis of these syndromes.

Report of a Case

A 34 year old white female was admitted to Columbus Hospital on March 17, 1965 because of weakness and pain in the chest. The pain is precordial and is radiating to the left shoulder, left arm to the wrist, especially after exertion, but ocassionally occurs during the night and is accompanied with numbness and tingling sensations. It lasted generally about five minutes and it is a severe pain, sometimes as a pressure. These complaints started in June, 1963 two months after open cardiac surgery (Dr. Kirlin—Mayo Clinic, April, 1963). She had a previous closed commissurotomy in 1958. Other complaints were shortness of breath, palpitations and edema of the ankles. The patient is a known case of mitral stenosis since 1951.

In July and August, 1963 she was rehospitalized in Mayo Clinic because of pneumonitis and pleural effusion and was told that these complaints were related to her cardiac surgery.

She was next hospitalized in October 1963 and given defibrillation shock followed by improvement. The patient's condition was good until June, 1964 when she again re-required defibrillation, to be repeated in October and December 1964.

Since December, 1964 pronestyl (being allergic to quinidine), digitalis, anti-coagulants, hydrodiuril and penicillin were given. The patient has been receiving penicillin orally since 1951.

She has a history of cardiac failure in 1952 (dyspnea of exertion, edema and ascitis) when digitalis and diuretics were given. There is no history of rheumatic fever.

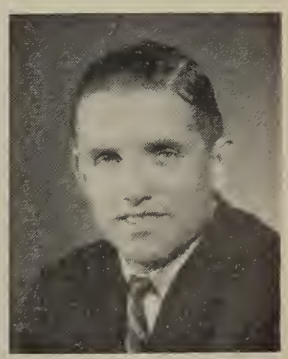
Past History

Patient had appendectomy and removal of right ovary in 1946, and cholescystectomy in 1959, but she continued to complain of pain in the right upper quadrant. Coccix bone was removed in 1952 after an accident. She has had two episodes of pneumonia, chronic kidney infection and peptic ulcer in 1960.

Physical Examination

On admission patient was normally developed, and in no acute distress, but with





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slight respiratory difficulty and apprehension. Temperature was 98.2°, pulse 84 and irregular, blood pressure 100/80. There was no cough and no engorgement of the neck veins. Lungs were clear. Heart: PMI felt slightly beyond the left midclaviculor line at 5th intercostal space. Rhythm was irregular. First sound was loud. Grade 3-4 systolic murmur, almost thruout the whole systole. Low pitched diastolic murmur just inside the apex. Heart rate 88. Pulmonary area: loud second sound.

Abdomen was soft and not distended, but the liver could be palpated 3 cm. below the right costal margin and was tender. The spleen was not palpable.

Extremities: No deformities or clubbing of the fingers. There was slight edema of the ankles.

Laboratory data revealed the following: HB 78%, (11.7g.), red blood cells 4,190,000. White blood count per cubic millimeter 7,700, with normal differential; erythrocyte sedimentation rate 38 mn. VDRL non-reactive. Blood urea nitrogen 10 mg. per cent.

Electrolytes: Na 151, potassium 4.0, chloride 103.4, CO_2 27.6 in Meq.

Serum amylase was 105U. and 120U. urinary amylase 200U. Urinalysis for protein, sugar and acetone were negative; WBC 8-10.

T-3 uptake 22.5% (within hypothyroid range). The electrocardiogram showed atrial fibrillation, digitalis effect and left ventricular hypertrophy.

Chest X-ray: showed slight cardiac enlargement and passive congestion.

Stomach X-ray: Minimal deformity of the bulb due to old scarring. No other abnormality of the stomach and duodenum was demonstrated.

Pulmonary function tests: VC 1.77 L. 5% of normal; MBC (Maximal Breathing Capacity) 52 L/Min., 63% of normal. Conclusions: Mild reduction of MBC with moderate reduction of VC, explained in basis of cardiac disease (Dr. Amaral and Dr. Choudhury).

Phonocardiogram: There was evidence of a prominent systolic murmur and a very prominent early diastolic murmur, both at the apex. (Dr. Gerald Nora).

Hospital Course

During the hospitalization the patient had episodes of tachycardia and precordial pain with numbness in the left arm. She also complained of pain in the right hypochrondrium and epigastric area with nausea. The patient received the following therapy: bed rest, anticoagulants, digitalis, diuretics, antacids, anglesics, tranquilizers, vitamin B_1 and B_6 and low-salt diet.

The patient was discharged from the hospital after 19 days, much improved with the diagnosis of Atrial fibrillation, Mitral stenosis and insufficiency, early decompensation and Postpericardiotomy syndrome. On out-patient follow-up she returned on July 9, 1965 to state a continued improvement. Lungs were clear, heart rhythm irregular, rate 86, tender liver, no edema. She was able to resume all works of a housewife.

Discussion

The pathogenesis of the post-pericardiotomy and post-myocardial infarction syndrome is still unclear and debatable; of interest is the suggestion of Dressler, that the myocardial necrosis may lead to antigenetic changes, which elicits in predisposing individuals, an autoimmune response.

Van der Geld found antiheart antibodies in these syndromes, but this author also found antiheart antibodies after cardiac surgery in sera of patients without signs of post-pericardiotomy syndrome.[5]

The fact remains an important finding, but the significance of auto-antibodies in these syndromes or auto-immune diseases is unknown, because the question is if these auto-antibodies are only the consequence of the pathological process of it, in addition, they could at a later time have a causative role. In our opinion the present knowledge in this problem permits us to consider the auto-antibodies to be the consequence of the cardiac lesions; and clinically they have the same significance as other findings, secondary to the myocardial necrosis, for example, the increased transaminases. (Current opinion is that the antibodies in past cardiotomy syndrome are not tissue damaging; that is that these antibodies do not react with tissue antigen, in vivo.) It remains to the future to prove if they are also casual agents or not. Other relationships between auto-antibodies and autoimune diseases are discussed recently in the medical literature. [1,4]

In our hypothesis the casual agent of

(Continued on page 101)

Coronary Artery Occlusion with Myocardial Infarction in a Twelve Year Old Boy — Two Episodes with a Fatal Outcome

By James D. Gross, M.D. and William C. Schiffbauer, M.D./Streator

The possibility of coronary artery occlusion in childhood and adolescence is not well appreciated clinically. The youth in this case experienced two coronary occlusions, the first passing unrecognized clinically and the second resulting in death.

Report of a Case

Clinical History. — This twelve year old white male was in apparent good health and led a relatively normal life until the time of his sudden unexpected death while watching television. A few days prior to death he had developed a mild upper respiratory tract infection, consulted a physician and was treated. No evidence of more serious disease was elicited at that time. The patient had been a quite active player one year previously in Little League baseball. Members of the patient's family had no history of cardiac disease or hereditary disease. No recorded blood pressure readings were found after review of all available records.

Gross Autopsy. — The body weighed 137 lbs. and was 59 inches long. The body was very obese with the fat distributed in a female pattern. The testes and penis were small. A few hairs were present in a feminine distribution above the symphysis pubis. The neck was quite short and the head sat practically upon the chest, making dissection very difficult. No x-rays of the cervical spine were obtained. The cranial cavity, brain and pituitary were examined and were without abnormality. The neck organs were without abnormality, save for some mild enlargement of the lymph nodes bilaterally. The axillary lymph nodes were also slightly enlarged.

The heart weighed 410 grams. The ventricular myocardial walls measured: left 12 mm., right 2 mm. The foramen ovale was closed as was the ductus arteriosus. The valves were without abnormality. The coronary arteries presented several abnormalities. The circumflex branch of the left coronary artery was a vessel 1.5 mm. in diameter and was without abnormality. The anterior descending branch of the left coronary artery measured 1.5 mm. in diameter. The lumen of the anterior descending branch of the left coronary artery 1 cm. distal to the bifurcation ended abruptly. In the area ordinarily occupied by the lumen of this vessel was a 1.5 mm. in diameter, 5 mm. long, very firm, calcified, gray-tan, cylindrical plaque. The lumen of the vessel could not be traced through this plaque. Distal to the nodule the anterior descending branch of the coronary artery regained its lumen. No other plaques were found in the left coronary artery.

The right coronary artery provided the outstanding pathology in this case. Three orifices were present in the right aortic sinus of Valsalva. The two smaller orifices led into very short, 0.5 mm. in diameter vessels which extended for 15 mm. into the adjacent epicardial fat and then ended. No plaques were found in these small vessels.



James D. Gross, M.D., (right), Director of Laboratories at St. Mary's Hospital, Streator, received his M.D. from Vanderbilt Medical School. He served a rotating internship at the U.S. Naval Hospital, St. Albans, Long Island, N.Y., and a residency in Anatomic and Clinical Pathology at the Bethesda, Md., Naval Hospital. Dr. Wm. Schiffbauer received his M.D. from Northwestern University Medical School. He served an internship at Evanston Hospital Assn. as well as a partial residency in surgery.

The major orifice led into the major portion of the right coronary system. The right coronary artery was much the larger of the coronary arteries in this patient, measuring up to 3 mm. in diameter. The right coronary artery contained firm, yellow plaques that encroached upon the lumen slightly for a distance of 15 mm. from the orifice. Distal to this point no plaques were found. Beginning immediately at the orifice and extending for 7 cm. a huge blood clot completely occluded the lumen of this vessel. The blood clot was adherent to the plaques in the wall of the vessel. The posterior interventricular septum and the posterior portion of the left ventricular myocardium contained a 5 cm. in diameter region of marked softening. A central green-yellow area with scalloped borders was surrounded by an area of recent hemorrhage. This tissue was much softer and more friable than the surrounding red-brown myocardium. The apex of the heart contained a 2 cm. in diameter area in which the wall measured only 3 mm. in thickness, composed entirely of dense, firm, white tissue. There was also a 5 x 5 x 1 cm., dense, firm, white scar in the anterior portion of the interventricular septum.

Lungs and Abdominal Organs

The lungs together weighed 510 grams and contained a slightly increased amount of clear colorless fluid. Bilaterally there was marked focal dilatation of the bronchi. In several scattered areas close to the pleura, bronchi 3.5 mm. in diameter were encountered. The abdominal organs were in the usual anatomical position, save for protrusion of the liver 4 cm. inferior to the right costal margin in the mid-clavicular line. The liver weighed 1350 grams and was red-brown, firm, homogeneous and without abnormality. The gallbladder was normal. No stones were present. The spleen weighed 280 grams and was composed of rather homogeneous, blue-red tissue. The lymphoid follicles were quite prominent. The pancreas and adrenals were without abnormality. The kidneys together weighed 290 grams. Several small cysts measuring from 1 to 4 mm. in diameter, lined by glistening, transparent tissue were present in both kidneys. These cysts did not occupy a significant volume of these organs. The renal pelves, ureters and bladder were normal. The testes were those of a prepuberal male. The gastrointestional tract was without abnormality. The mesenteric lymph nodes were moderately enlarged.

Microscopic Autopsy. — Sections of the right coronary artery in the grossly somewhat thickened proximal 15 mm. segment revealed marked intimal thickening due to cellular proliferation and to production of an increased amount of fibrous connective tissue, some of which had become hyalinized. Many cholesterol clefts were present in the intima and small calcium deposits were seen in the intima and media. The internal surface of the intima was rough and irregular and a large thrombus was attached to this area. The thrombus completely filled the narrowed lumen. Sections of the left coronary artery in the area of the cylindrical plaque revealed marked thickening of the intima, with obliteration of the lumen due to cellular proliferation and to production of a very large amount of fibrous connective tissue, much of which had become hyalinized. Many cholesterol clefts were present in the intima and many large calcium deposits were seen in the intima and media. In some scattered areas dilated capillaries were seen in the intima. No other changes were seen in the previously described portions of the coronary arteries and the remaining portions of the coronary arteries showed no abnormality.

Sections of the thin portion of the left ventricular wall near the apex revealed destruction of almost all muscle fibers. The muscle fibers were replaced by dense, eosinophilic, relatively acellular fibrous connective tissue. No acute or chronic inflammatory cells were present and no recently extravasated red blood cells or hemosiderin-containing macrophages were seen. Sections of the anterior portion of the interventricular septum revealed widespread destruction of the muscle fibers and replacement by relatively acellular dense, eosinophilic fibrous connective tissue. No acute or chronic inflammatory cells were present and no recently extravasated red blood cells or hemosiderin-containing macrophages were seen.

Sections from the posterior portion of the interventricular septum in the area of the gross softening, supplied by the right coronary artery, revealed massive recent destruction of myocardial fibers. Fragmentation of muscle fibers, brilliantly eosino-

philic staining reaction of some muscle fibers, loss of cross striations, and karyorrhexis, pykosis and karyolysis of muscle fiber nuclei were prominent changes. The central portion of the lesion contained a heavy infiltrate of neutrophilic polymorphonuclear leukocytes. Surrounding this central area, the peripheral portions of the lesion showed less prominent necrosis of muscle fibers, and recently extravasated red blood cells were present in large numbers in the edematous interstitial connective tissue. White blood cells were not present in the interstitial tissue in these peripheral portions of the lesion.

Sections of the lungs revealed congestion of the alveolar wall blood vessels. A small amount of fibrin was present in a few alveolar spaces. No other pulmonary lesion was found after examination of several sections. Sections of the liver revealed atrophy of the central parenchymal cells and dilatation of the central sinusoids, with congestion of these sinusoids by red blood cells. A few fat vacuoles were present within the parenchymal cell cytoplasm. Sections through the spleen revealed some congestion of the red pulp but no other abnormality. Sections of the adrenal glands revealed no abnormality. Sections of the appendix revealed lymphoid hyperplasia but no other lesion. Sections of the kidneys revealed scattered, very dilated tubules and infiltration of the interstitial tissue by a few mature lymphocytes. Sections of the testes revealed no spermatogenesis. Increased fibrous connective tissue was present in the interstitium. Sections of the brain, brain stem and pituitary gland were not abnormal.

Discussion

This case is presented because of the young age of the patient. A previous nonfatal left coronary artery thrombosis and myocardial infarct had occurred probably prior to the age of eleven and had been undetected. The boy had continued his usual activities without apparent modification, only to suffer a second right coronary artery thrombosis and myocardial infarct, resulting in death. Unfortunately, blood pressure readings of this patient were not available. Studies of blood cholesterol on this patient and his family were not performed.

Talbot[1] reported the case of a seven year old white male with progeria who developed atheromatous coronary disease and who sustained a myocardial infarction. Jokl and Greenstein's[2] ten year old patient is the youngest reported case of death due to coronary atherosclerosis in childhood in a patient without progeria. It is believed that this case represents the youngest reported patient to have suffered two chronologically distinct myocardial infarcts caused by thrombosis of atherosclerotic coronary arteries.

Summary

This is a case of a twelve year old white male who was quite active and led a relatively normal life until the time of his death. A few days prior to death, the patient developed a mild upper respiratory tract infection. He consulted a physician and was treated for this condition. While watching television at home the patient suddenly expired.

Autopsy revealed marked coronary atherosclerosis of a degree quite unusual for a child of this age. Thrombosis of the anterior descending branch of the left coronary artery had occurred some time in the past, with resultant myocardial infarction of the anterior interventricular septum and anterior left ventricular wall. Myocardial hypertrophy and fibrosis followed the development of the atherosclerosis, thrombosis and myocardial infarction. The myocardial infarction resulted in marked thinning and fibrosis of the apex of the left ventricle, giving rise to the aneurysm of the left ventricular chamber in that region. These changes were followed by chronic passive congestion of the liver and spleen. The patient then suddenly died of a very recent thrombosis of the right coronary artery resulting in myocardial infarction of the posterior interventricular septum and posterior left ventricular wall.

References

1. Talbot, N. B., et al: Progeria; Clinical, Metabolic and Pathologic Studies on Patient. American Journal of Diseases of Children, 69:267, 1945.
2. Jokl, E. and Greenstein, J.: Fatal Coronary Sclerosis in a Boy of Ten Years, Lancet 2:659 (Nov. 18) 1944.
3. Stryker, Walter A.: Coronary Occlusive Disease in Infants and Children, American Journal of Diseases of Children, March, 1946.

Fusion Of The Labia Minora

By Marc I. Rowe, M.D./Chicago

In the past year we have treated four young girls with fusion of the labia minora. None of these patients had the correct diagnosis made before referral to the hospital. The first girl was a six-year-old referred from the pediatric service for x-ray and endocrine evaluation of intersex. A seven-year-old was brought to the hospital by two grief-stricken parents who had just been told by their physician that their daughter was born without a vagina. The third patient, twenty-two months old, was sent to the surgical service by a pediatrician for surgical correction of a minute vaginal opening. The final patient was four years old and had a referring diagnosis of "congenital anomaly of the genitalia." All of these girls had typical fusion of the labia minora that was simply and quickly treated. This relatively common and innocuous lesion is apparently not well recognized or managed, resulting in needless apprehension in the patient and her family and unnecessary referrals.

Etiology

Campbell, in 1940,[2] suggested that fusion of the labia minora was a congenital anomaly. He felt that during the third and fourth month of fetal life, embryologic midline fusion of the labioscrotal folds occurred similar to the merging of the two scrotal folds in the male. Currently it is generally accepted[1,2,4,5,6] that labial fusion is an acquired condition resulting from an episode of vulvovaginitis. Several facts seem to substantiate this. (1) The labial folds develop from the edges of the genital tubercles and are not fused in any stage of fetal development.[3,5] (2) Fusion of the labia minora is seen in infants and children but not neonates. There is only one reported case of fusion in a newborn.[1] (3) There is often a documented history of genitalia previously observed to be normal. Fifty-seven of Nowlin, Adams, and Nalle's[5] 110 patients with labial fusion had normal vaginal examinations at birth. (4) A preceding history of vulvovaginitis frequently can be elicited. Forty-seven per cent of Vakar's[7] patients had such a history. (5) The lesion has recurred in as many as 20 per cent[5] of the patients after surgical separation. (6) Separation of the labial fusion follows local[3,4] or systemic[6] estrogen therapy without mechanical efforts to separate. (7) Spontaneous separation occurs just before the menarche when estrogen levels rise. (8) Congenital anomalies are not common in these patients.[5]

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Pathogenesis

The newborn's external genitalia are stimulated by maternal estrogen. After a few months the estrogen level drops and continues at a relatively low level until the premenarche. Until the increase in estrogen concentration which then occurs the bacterial flora of the vagina is quite different from the adult, and the pH of the vagina is alkaline. Vulvovaginitis is believed to result from an exaggeration of the physiologic hypoestrogenism of the child. A low grade inflammation, similar to senile vaginitis, develops and the subsequent erosions and inflammation of the closely approximated labia minora lead to adhesions and fusion.

Clinical Characteristics

The lesion is most commonly seen in girls between the ages of two and six years. A history of preceding vulvovaginitis characterized by a thin, watery, yellowish discharge, reddened vulva, pain and pruritus sometimes will be obtained. The parents' recollection or the patient's record may indicate that the genitalia previously had been normal. In about 20 per cent of the cases[5] urinary symptoms will be noted. Deviations of the urinary stream, straining dysuria, pyuria, and low abdominal pain will then be reported.

The physical findings are typical. Gentle retraction of the labia majora reveals a single opening between the pubis and the anus. The vaginal orifice, clitoris, and urethral meatus are not visible. The labia

minora are sealed together by a thin, red median line, often semi-transparent. The single aperture is commonly in the subclitoral area and can be quite small. A probe passed through this opening and directed downward and outward will demonstrate the thinness of the line of fusion, and frequently produce separation. Once the fusion has been broken, normal urinary and vaginal orifices are visible.

Complications

This condition usually causes little trouble, and the main concern is over the psychic trauma sustained by the child and her parents. Urine collecting in the gutter, behind the fusion, may reflux into the vagina causing a severe vaginitis, or seep onto the perineum and produce a refractory ammonia dermatitis. Urinary tract infections have frequently been blamed on the relative obstruction to the urethral meatus produced by the fusion.[5] No urinary tract anomalies were found in these patients by urologic investigation and their infections were invariably cured by labial separation and systemic antibiotics.

Treatment

Daily applications of estrogen cream to the vulva usually results in nontraumatic separation of the labia in several days. Several authors[1,2,5] found surgical separation, either by blunt dissection or incision rapid and simple. With heavy adhesions, or when a urologic evaluation is to be done, anesthesia is employed. The recurrence rate with surgical separation, however, has been as high as 20 per cent.[5] Teton and Treadwell[6] believed surgical separation or local estrogen applications produce psychic and physical trauma to the young girl that may cause difficulty in her later sexual adjustments. They recommended oral estrogen for ten to fourteen days. The labial adhesions disappeared in both their patients but slight enlargement of the breast, darkening of the areola, and growth of pubic hair occurred.

We recommend the following therapeutic plan. (1) If the fusion is thin it will frequently begin to separate during the initial examination. With gentle but firm spreading of the labia, complete separation can be completed quickly and relatively painlessly. The fusion can also be broken down by manipulation of a probe or curved clamp placed in the defect in the adhesions. (2) Following separation, estrogen cream should be applied by the mother for three or four days to prevent recurrence. (3) If the adhesions are heavy and do not separate easily estrogen cream is applied for four or five days. (4) If the labia fail to separate with local estrogen therapy the adhesions are divided with a scalpel under anesthesia. Bleeding is minimal and no sutures are needed to repair the cut edges. If the patient requires anesthesia for cystocopy or other reasons, separation can be done at this time. Estrogen cream should be applied in the postoperative period.

Summary

Fusion of the labia minora is an acquired condition resulting from the nonspecific vulvovaginitis of childhood. Local application of estrogen cream or surgical separation are simple and successful methods of treatment.

References

1. Bowles, H. E., and Childs, L. S.: Synechias of Vulva in Small Children, *Am. Journ. Dis. Child.*, 66:259, 1943.
2. Campbell, M.F.: Vulvar Fusion; Its Urogynecologic Interest, *J.A.M.A.*, 115:513, 1940.
3. Craig, D.S.: Fusion of the Labia Minora in Infancy, *The Practitioner,* 196-424, 1966.
4. Huffman, J. W.: Disorders of the External Genitals and Vagina, *Pediat. Clinics N. Am.,* 5:36, Feb. 1958.
5. Nowlin, P., Adams, J. R., and Nalle, B. C., Jr.: Vulvar Fusion, *Jour. of Urology,* 62:75, 1949.
6. Teton, J. B., and Treadwell, N. C.: The Management of Nonspecific Vulvitis in Children, *Am. Jour. of Obst. & Gyn.,* 72:674-676, 1956.

The Veterans Administration can now provide nursing care in practically every town in the country. By using contract nursing homes for care of convalescents and the aged, VA has freed 4,000 beds in its 166 hospitals for use by the more acutely ill while nursing care patients can stay closer to home.

World War II veterans who have not already used their eligibility for G. I. loans and whose individual eligibility has not expired are reminded that the final cut-off date for their participation in the G. I. loan program has been extended until June 25, 1970.

Clinical Experience with a New Topical Corticosteroid, Betamethasone 17-Valerate

By Roy A. Hecht, M.D., F.A.A.A., F.A.C.A./Kankakee

Betamethasone 17-valerate—a new ester of betamethasone developed through intensive research in England and at Schering Corporation, has recently become available in this country as Valisone Cream 0.1%.

During its investigational phase, clinical studies of betamethasone 17-valerate cream 0.1% and 0.05% and ointment 0.1% and 0.05% were made by this writer. This brief report describes clinical experience with this new topical corticosteroid in all four formulations.

In double-blind paired-comparison trials, betamethasone 17-valerate has been found as effective as or more effective than fluocinolone acetonide. Mitchell et al.[1] and Coburn[2] reported that betamethasone 17-valerate cream 0.1% was equally effective as fluocinolone acetonide cream 0.025% and 0.01%, respectively, in 50 and 25 patients respectively. Ross[3] compared the following preparations in 196 trials:

betamethasone 17-valerate cream 0.1% and ointment 0.1%, fluocinolone acetonide cream 0.1% and ointment 0.01%, two cream bases, two ointment bases.

Statistical analysis of the results showed no significant difference among the active drugs though all four were superior to the bases without active ingredients.

Comparison With Other Ointments

A group of seven investigators[4] in as many clinical centers in England collaborated in a clinical study involving 345 patients with psoriasis and 462 with eczema. They compared betamethasone 17-valerate ointment 0.1% with five other topical corticosteroids, all applied with and without occlusion, in a double-blind paired-comparison trial. The other ointments were fluocinolone acetonide 0.025%, triamcinolone acetonide 0.1%, flurandrenolone 0.05%, betamethasone phosphate 0.1%, and hydrocortisone 1.0%. In patients with psoriasis, betamethasone 17-valerate was judged more effective than the corticosteroid being compared with it in 40% to 75%, less effective in 6% to 15%, and equally effective in 19% to 45%. In patients with eczema, betamethasone 17-valerate was judged more effective than the corticosteroid being compared with it in 27% to 60%, less effective in 13% to 18%, and equally effective in 27% to 56%. Statistical analysis of the overall results showed betamethasone 17-valerate to be more effective than all the other compounds.

Zimmerman[5] made a double-blind paired-comparison trial of 17-valerate ointment 0.05% and fluocinolone acetonide ointment 0.025% in 54 patients with bilateral, symmetrical lesions. The results were as follows.

Betamethasone 17-valerate superior	37 (69%)
Fluocinolone acetonide superior	1 (2%)
Both equally effective	16 (29%)

Thus, betamethasone 17-valerate was as effective as or more effective than fluocinolone acetonide in 53 of 54 patients (98%).

Report of Study

This investigator conducted a clinical trial of betamethasone 17-valerate in 97 patients with various allergic dermatoses. The diseases treated and the formulations administered are presented in Table 1.

Since betamethasone 17-valerate will be



Roy A. Hecht, M.D., F.A.A.A., F.A.C.A., is engaged in the practice of allergy. He received his medical training at the Chicago Medical School and served his internship and residency at the Hospital of St. Anthony De Padua, Chicago. Dr. Hecht is consultant in allergy, St. Mary's and Kankakee State Hospitals.

Table I

TYPES OF DERMATOSES TREATED WITH BETAMETHASONE 17-VALERATE, BY FORMULATION

	Cream		Ointment		Total No. of Patients
	0.1%	0.05%	0.1%	0.05%	
Atopic eczema (acute)	1	8	6	12	27
(chronic)	-	5	-	6	11
Eczematoid dermatitis	2	4	2	1	9
Atopic dermatitis	1	5	3	4	13
Dermatitis venenata	2	6	5	5	18
Detergent dermatitis	2	1	2	3	8
Other contact dermatitis	1	-	2	-	3
Seborrheic dermatitis	-	-	2	1	3
Pruritus	-	2	-	-	2
Atopic neurodermatitis	-	-	-	1	1
Axillary erythrasma	-	-	1	-	1
Psoriasis	-	1	-	-	1
Totals	9	32	23	33	97

used adjunctively with other drugs, particularly by physicians treating allergic dermatoses, an evaluation of this concomitant use is timely. Only 33 patients in this study were treated with betamethasone 17-valerate alone. All the others received concomitant treatment with ACTH, or with other topical or systemic corticosteroids, or with antihistamines or other agents. About 40% of the patients had a chronic or recurrent disease that either had persisted or recurred periodically for a year or more. No occlusive dressings were used with any of the patients. Betamethasone 17-valerate was usually applied twice a day. About two-thirds of the patients were treated for only one or two weeks. Only 15 patients required treatment for more than three weeks.

Results

Responses were judged as follows: *Excellent:* Relief or pruritus, burning, and stinging within 24 hours; relief or erythema, weeping, oozing, and edema in 2 to 3 days; subsequent control of flare-ups. *Good:* Delayed or less than complete response of subjective and objective symptoms. *Fair:* Little or no response. *Poor:* No improvement or worse.

The results of 97 patients were evaluated as follows:

Excellent	61	(63%)
Good	33	(34%)
Fair	3	(3%)
Poor	0	

The results by formulation were as follows:

Formulation of betamethasone 17-valerate	Exc.	Good	Fair
cream 0.1%	7	2	0
cream 0.05%	14	18	0
ointment 0.1%	18	5	0
ointment 0.05%	22	8	3
	61	33	3

Discussion

In terms of percentage of excellent results, the 0.1% formulations were somewhat more effective than the 0.05% formulations (80% compared with 40 to 60%), as would be expected. There were no treatment failures. No adverse effects were observed. Although an allergic population was being treated, no hypersensitivity reactions to the drug occurred. The medication was well received and well tolerated. There was no clinical evidence of systemic absorption, though no laboratory measurements were performed. Thus, betamethasone 17-valerate proved to be a useful new agent for inclusion in the regimen of therapy for allergic dermatoses.

Summary

This investigator used a new ester of betamethasone—betamethasone 17-valerate—in four topical formulations to treat 97 patients with allergic dermatoses. The numbers of patients who received each formulation were as follows: 0.1% cream 9, 0.05% cream 32, 0.1% ointment 23, 0.05% ointment 33. Most of the patients received the medication twice a day, and over 80% were treated for only three weeks or less. Therapeutic results were: 61 excellent, 33 good, 3 fair, and 0 poor. The 0.1% formulations were somewhat more effective than the 0.05%, as would be expected. No adverse effects, including hypersensitivity reactions, were seen. There was no clinical evidence of systemic absorption. The medication was uniformly well accepted and well tolerated. Betamethasone 17-valerate (Valisone) is an effective new agent for adjunctive treatment of allergic dermatoses.

References

1. Mitchell, D. M., et al.: Betamethasone 17-valerate. A clinical trial of a new topical steroid, J. Irish Med. *55*:44-45 (Aug.) 1964.

(Continued on page 108)

Community Immunity How, When And How Much?

By Herbert S. Lipschultz, M.D. Ward Duel, M.P.H. and Seymour Diamond, M.D.

The Skokie Board of Health in past years and again in 1967, was presented with the request from the local community and the recommendation of the United States Public Health Service to "eradicate" measles. Since there had been differences of opinion concerning the community need for a "Measles Day"* approach to mass immunization, a committee was appointed to further study the problem.

The Village of Skokie is somewhat unusual. It has a high percentage of professional people in the community—physicians and lawyers with Chicago offices, professors from nearby Northwestern University, and owners and managers of successful businesses. It is a young community with a median age of 30.6 years. In the last twelve years, the number of homes increased over 300%; the median value of homes is $27,300. School health records indicate that the overwhelming majority of the children are cared for privately and immunizations are current.

The Decision

From the above, the committee felt that a very large percentage of the children would be under private care and might well already have been immunized. It was, therefore, recommended that a careful survey was in order to first determine the *need* for a mass immunization program.

Other recommendations included a simple technique for accomplishing a mass survey (rather than the usual "sampling" procedure) with almost negligible cost. The uses of the existing organizational structures of the public and parochial schools, churches, synagogues, pre-school nurseries and in addition, the "woman power" of the Parent Teacher Association and the Association of University Women. The extraordinary cooperation of available personnel of the PTA and AUW more than made up for what might otherwise have been an excessively costly and overambitious project.

The response of the public in the provision of services was tremendous. An informal tabulation indicated that over 1,000 people participated and the total cost to the community for the entire survey was 0.6 of one cent per respondent! Over 11,000 children, ages one through twelve (2/3 of the total estimated population in this age group) responded.

The Procedure

1. The full time professional staff of the Skokie Health Department obtained literature and consultative aid from the State Health Department and the U.S. Public Health Service.
2. This material as well as an information flyer and a questionnaire printed locally was distributed to the public, parochial and nursery schools.
3. The packets of literature and the questionnaire (a tear-off slip of paper) were distributed by teachers, nursery school directors, ministers, rabbis and priests in their respective schools to the children.

Special efforts were directed to the pre-school population through a telephone survey and newspaper reproduction of the questionnaire. Over thirty radio and numerous church announcements advised parents of pre-school children where forms could be obtained.

Setting Up the Survey

In order to prevent prejudiced decisions by post facto decision-making, the following statistical measles program guidelines were established in consultation with Dr. Walter Buell, UPHS Consultant to the IDPH for the measles eradication program:

80-85% immune—assume community is approaching herd immunity, and/or eradication levels and conduct mail effort to susceptibles

*** The United States Public Health Service uses the word "eradication" to denote that level of immunity in a community which prevents the occurrence of secondary cases within the incubation period of that disease.**

75% immune—assume community need not be concerned about an epidemic, and direct immunization to groups identified in the study

70-75% immune—plan effort for a Sunday mass immunization. (Physicians on the Skokie Board of Health volunteered to contribute their services if such a program proved necessary)

Results

Sixty-seven different groups were tabulated according to their susceptibility and immunity within the group. Among these were five public school districts (divided into 14 buildings), five parochial schools, and eight nursery schools.

The tabulated results show that Skokie is a remarkably well-protected community in that the general susceptibility of the combined group is only 4%; only 2.7% of the school age children are susceptible; and only 7% of the pre-school children are susceptible. Where the survey revealed differences between one of the identified groups of children and the total studied population, special studies were made. In one district both the school and pre-school susceptibles clustered around an area of older homes. Some of these homes are being torn down, and apartment buildings are being built. None of these susceptibles lived in the apartment buildings. Further investigation revealed that the results from

TABULATION OF SURVEY RESULTS BY AGE GROUPS AND SOURCE OF STATISTICS

	1 thru 12 years			1 thru 5 years			6 thru 12 years		
	No. Rep.	No. Sus.	% Sus.	No. Rep.	No. Sus.	% Sus.	No. Rep.	No. Sus.	% Sus.
Public Schools	8647	285	3%	2175	141	6%	6472	144	2%
Parochial Schools	1975	124	6%	389	47	12%	1586	77	5%
Nursery Schools	382	3	1%	277	3	1%	105	0	0%
Miscellaneous									
Telephone	127	2	2%	127	2	2%	—	—	—
Newspaper	28	3	10%	17	2	12%	11	1	9%
GRAND TOTAL	11,159	417	3.7%	2,985	195	6.5%	8,174	222	2.7%







Herbert S. Lipschultz, M.D. (left), is on the attending staff of Edgewater Hospital and Bethesda Hospital, Skokie, as well as being in the private practice of internal medicine. He received his M.D. from the Chicago Medical School and interned at White Cross Hospital, Columbus, Ohio, where he also took his residency in internal medicine. Ward C. Duel, M.P.H., (center) is Director of the McHenry County Department of Health. He served as Director of the Skokie Department of Health previously. His M.P.H. is from the University of California at Berkeley. Seymour Diamond, M.D. (right), is a general practitioner and an Associate in Neurology and Psychiatry at the Chicago Medical School, from which institution he holds the M.D. He served an internship at the University of Arkansas Hospital and at White Cross Hospital, Columbus, Ohio. He presently serves on staff at three Chicago hospitals.

one school were skewed by a few large families, each of whom contributed a large number of susceptible children. Twelve percent of the pre-school children of families sending their children to parochial schools are susceptible to measles. This compares to less than 7% of the similarly aged children found in the rest of the community. As a whole, 27% of the susceptible children have parochial ties, even though they constitute only 15% of the children in the community. Only 1% of the pre-school age children in families which send their children to nursery schools are susceptible.

The high level of immunity of the nursery school children and their younger siblings is reflected by the health department's strong program in this area, which requires immunization before enrollment. Apparently the effect of this program has also reached the younger siblings of the nursery school students. This is confirmed by comparison with the miscellaneously reported children (those contacted by telephone and newspaper surveys) and the younger siblings of public and parochial students, all of whom have a significantly higher level of susceptibility. This survey can serve as a solid basis for program planning because of the remarkable internal consistency of the statistics, the large numbers tabulated, and the percent of the study population reached.

Examination of the Skokie measles survey statistics reveals that the community immunity is very high, and substantiates the fact that herd immunity has been achieved. This is also demonstrated by the fact that in the 1966-67 reporting season, only one primary case of locally-occurring measles was reported to the health department. No secondary cases were reported. Although no seriously susceptible groups were found by the survey, some lesser protected groups were identified.

Conclusions and Recommendations

1. The Skokie community surveyed had more than surpassed "eradication" level of measles immunization through the normal channels of private medical practice.
2. The lists of susceptibles would be used for transmitting additional information to the parents concerning desirability of measles immunization and vaccine made available for this purpose.
3. This mechanism of using large numbers of organized volunteers may be strongly recommended for use in community screening projects as well as determining the *need* for such community sponsored programs.

Summary

A mass survey approach to the determination of community need was used in Skokie, Illinois in relation to measles susceptibility. Over 11,000 responses were obtained demonstrating an overall immunity of approximately 96% in ages 1 thru 12. The use and cooperation of the organized Woman Power of the community, as well as the public and parochial school systems, made an otherwise overwhelming task both possible and simple. The technique is certainly usable for many and varied purposes.

FILMS AVAILABLE

Two films, each in two parts, running 30 to 38 minutes each in 16 mm., sound, B/W, are available to teach radiologists interpretation of mammography—an important diagnostic aid in the control and detection of breast cancer. Each film is restricted to showing by individuals listed in the Directory of the American College of Radiology. Radiologists not listed should direct an inquiry to: Program Representative for Mammography, Cancer Control Program, National Center for Chronic Disease Control, USPHS, DHEW, Washington, D. C. 20201. "Mammography Diagnosis: Normal, Non-Malignant Breast," and "Mammography Diagnosis: Malignant Breast Disease," were produced by the National Medical Audiovisual Center for the National Center for Chronic Disease Control. It is available only on short-term loan from the Audiovisual Center, Chamblee, Ga. 30005.



TUBERCULOSIS—TODAY

Tuberculosis is still a disease that people "catch" from one another. In the United States and a number of other countries, tuberculosis death rates have been reduced as much as 98 per cent since 1900. However, it still is the leading cause of death among infectious diseases caused by a single class of germ. The World Health Organization estimates that more than half the world's population has been infected by the tubercle bacillus, including 500 million children. Three million persons died last year and 15 million more were suffering from the disease.

The tuberculosis problem concerns all of us. We must recognize our responsibilities and lose our complacency.

With the introduction of effective chemotherapy in the 1940's came optimism that tuberculosis would be rapidly eliminated. This resulted in marked reduction in the number of beds for tuberculous patients and reduced numbers of tuberculosis residencies and grants, despite a definite need for more physicians with knowledge about the treatment and supervision of tuberculous patients. In fact, many cities are unable to secure qualified physicians for their chest clinics to replace those retiring. A recent survey of practicing physicians in Massachusetts, for example, revealed that lack of knowledge and misinformation on the current concepts of tuberculosis existed among a number of physicians interviewed.

Present improved diagnostic and therapeutic modalities give the physician a better armentarium with which to control and ultimately eradicate tuberculosis.

What shall we tell the public? For the past 10-20 years, we have prematurely advised that tuberculosis has been controlled and is being eradicated. Now they must be told the truth—every day—not only at Christmas Seal time—tuberculosis is still a real problem, locally, nationally and internationally.

It is essential that all old cases, treated and untreated, be followed indefinitely. This includes all contacts. Unfortunately, in many cities there are not sufficient health workers to follow even the active cases. It may be necessary to use lay personnel for proper follow-up of all active and "inactive" cases. All new or relapsing cases must be reported. If one inquires into case reports, there may be found inadequate, often inaccurate, or even unreported cases. In the past, we estimated the number of active tuberculous patients based upon deaths from tuberculosis. Today, this is no longer valid, making us more dependent upon initial and follow-up reports or postmortem findings.

In Lake County, Ill., we do have sufficient facilities, in the Tuberculosis Sanatorium, Tuberculosis Association and the County Health Department to carry on adequate "case finding" and "follow-up" activities.

The private practitioners of medicine can call upon these facilities to aid in their management of contacts, tuberculin con-

verters, inactive and active cases of tuberculosis.

Medicine has made and is making great strides. Let us continue tuberculosis programs, including the tuberculin converters as well as clinically active cases and carry out the most effective methods of management, treatment and prevention. Only with such a regimen can we control and ultimately eradicate tuberculosis. A continued active program, not words, will mean success.

Charles K. Petter, M.D.

Observations of a Run for Your Lifer or the Loneliness of the Short Distance Runner

Much has been written recently on the great value of running in the prevention of cardio-vascular disorders, especially coronary heart disease.[1-3] Dr. Thomas Cureton has done a vast amount of work in studying the physiology of exercise.[4] As a result of these publications many doctors advise some of their patients to start an exercise program which usually involves some running. Doctors who are physically able are also engaged in running at gyms and the Y M C A; however, it is still quite rare to see adults engage in running for exercise. One questions whether the patients are following their physician's advice.

I would like to advocate a type of running which I have carried out for several years. I have found that running to and from hospitals after parking at the far end of a hospital parking lot or at a distance from a house call can result in well over a half mile of running each day. This not only gives exercise to the lungs, heart, and leg muscles, but it is a great time saver for the perennially late physician. It should be recognized that this type of jogging would be in conjunction with a well organized program of exercise.

One drawback is that the doctor risks being accused of running for the almighty dollar by his less energetic colleagues, who may be unaware of the physician's true motive.

I have yet to observe another doctor run in or out of a hospital during my pleasant jogs. One still commonly observes many overweight physicians and nurses slowly trudging in and out of hospitals oblivious to the joys of running.

It is suggested that physicians set a shining example for all nurses and patients to see. Run, leap, lope, trot over those hospital parking lots. Preserve your youth by becoming a run for your lifer. Once you get accustomed to it, you'll find it difficult to go back to your sedentary ways.

Harvey Kravits, M.D.

References

1. Harris, W. E. et al. *Jogging. An Adult Exercise Program.* JAMA 201:759-761 (Sept. 4) 1967.
2. Currens, J. H. and White, P. D. *Half a Century of Running.* New Eng. J. Med. 265:988-993 (Nov. 16) 1961.
3. Fox, S. M., III and Haskill, W. L. *Physical Activity and Health Maintainance,* J. Rehab. 32:89-92 March-April 1966.
4. Cureton, T. K. *Physical Fitness and Dynamic Health.* Dial Press. New York, 1965.

We Study the Octopus

Cephalopods, members of the group to which squid belong, have contributed to our basic knowledge of neurophysiology. The common octopus possesses a highly evolved brain, capable of certain types of learning. The octopus is simple enough to lend itself to a large variety of experiments involving the effects of different situations, or drugs, or brain ablations (cutting off of parts) on the learning process. Yet its brain is complex enough to serve as a model for brains in general, our own included. Perhaps it is an exaggeration to say that octopuses have emotions as well; they do exhibit, however, some dramatic responses which have the appearances of rage and fear. These phenomena, and the other aspects of octopus behavior, are being extensively studied at many institutions. It would be surprising if this work did not significantly affect the medical study of the human brain and the treatment of its disorders. Michael Gruber. The Healing Sea. Sea Frontiers, 1968.



"TOTAL CARE"

Highlights of Convention

Summary of Actions of 1968
House of Delegates

128th Annual Convention
Illinois State Medical Society

1968-1969 OFFICERS AND BOARD OF TRUSTEES

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1st District	1971	Joseph L. Bordenave, 1665 South St., Geneva 60134
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10th District	1969	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
11th District	1971	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

Trustee-at-Large Newton DuPuy, 1101 Maine St., Quincy 62301

Chairman of the Board Frank J. Jirka, 1507 Keystone Ave., River Forest 60305

CONVENTION HIGHLIGHTS

Attendance Totals

In attendance at the convention were:

Physicians	1,640
Guests Woman's Auxiliary	516
Technical Exhibitors Scientific Exhibitors	350
TOTAL	2,506

Representatives of SAMA Urge ISMS Interest in Students

Representatives of the SAMA chapters at the five Chicago medical schools were at the sessions. Remarks for the five schools were presented by Joseph Valaitis, Jr., president of the chapter at Loyola University Stritch School of Medicine. Mr. Valaitis encouraged physicians to take an active role in organized medicine and to set the pace for the physicians of tomorrow. He asked support of SAMA activities by all physicians. A recent survey of pre-med students indicated that a significant number of them were not aware of the objectives of medical organizations. It is at this level that medical societies face a great challenge in stimulating concerted action among future doctors.

IMPAC Successes Reported

Dr. Philip Thomsen reported that Illinois is the leading state of the United States in the support of AMPAC. Over 45% of all physicians in Illinois maintain membership. Dr. Thomsen further reported that it is only through this type of support that medicine will be able to effectively introduce favorable legislation and defeat bad legislation on both the state and national level. In this election year, he further pointed out, these funds will allow for support of candidates favorable to medicine's cause. The number of seats in the house with only a 5% differential in the 1966 election is so significant as to warrant special attention by physicians through PAC groups.

President Addresses House of Delegates

Newton DuPuy, at the conclusion of his year as ISMS president addressed the house and thanked the physicians for their excellent support during the year. He recounted his many travels around the state and to sister states, which took him over 30,000 miles on a total of 93 days away from home and lamented the fact that he hadn't done more. He encouraged the members of ISMS to continue their interest in the course of medicine and organized medicine and indicated he was available to serve further in any capacity he could.

Special Committee on Self-Examination Encouraged

Insufficient evidence to reach a decision regarding voluntary participation in self-examination made necessary a reference committee request for a Board committee to hear evidence regarding this concept for report at next year's convention.

Mexican Fiesta President's Party

The annual president's party was held in the grand ballroom and took on the motif of Mexico with a Mexica Fiesta. Dancing to the mariachi band and the mexican dance band were many ISMS members and their guests. A buffet was served.

Aesculapius Award to Drs. Schumer & Sperling

The Mead Johnson Aesculapius Award was made to Dr. William Schumer and Dr. Richard Sperling for their exhibit on Shock and Its Effect on the Cell. For originality Dr. Edward K. Isaacson from the University of Illinois Medical Center received the gold award, while the gold award for an educational exhibit went to Dr. Edward M. Goldberg and Dr. Ralph N. Bransky of Michael Reese Hospital.

Dr. Frank Jirka New Board Chairman

At the Wednesday post-convention meeting of the Board of Trustees, Dr. Frank J. Jirka, Jr., was unanimously selected to be Chairman of the Board. Dr. Jirka, a urologist, is a trustee from the 3rd district and lives in River Forest. He succeeds Dr. Arthur Goodyear.

AMAA Illinois Chapter President Thanks ISMS

Mrs. Helen Smith, president of the Illinois Chapter of the American Medical Assistants Association, addressed the House and thanked the State Society for the interest and effort expended in behalf of the medical assistants. She felt there was a definitely good rapport between the associations and that the programs of ISMS geared



Miss Elizabeth Lynch (left) ISMS Staff greets the first registrant to the 128th Annual Convention, Dr. Robert R. Hartman, Delegate from Jacksonville and Chairman of the ISMS Maternal Welfare Committee. The convention had an attendance of over 2,500 physicians, guests, auxilians and exhibitors.

to the needs of the assistants were a definite asset in furthering the aims and educational objectives of IMAA.

$127,758 Presented to Five Medical Schools

President Newton DuPuy presented a check in the amount of $127,758 to Dr. William Grove, Dean of the University of Illinois College of Medicine, to be apportioned among Chicago's medical schools for use in building the programs of education at the institutions. Dr. Grove indicated that these funds are invaluable as they allow the inception of new programs before budgeted funds are available, allow the completion of research on special projects and studies, or allow the employment of specialists to broaden the perspectives and horizons of the students. The funds are especially welcome as there are no special requirements as to their disposition other than that they be used to further education.

Senator Murphy Addresses Public Affairs Dinner

Presenting the annual Camp Memorial Lecture at the Public Affairs Dinner was Senator George Murphy (R.-Calif.). An entertaining speaker, Senator Murphy reviewed fiscal policy, civil disorders, problems of youth, foreign aid and Southeast Asia. He called for persistence in achieving our goals, victory in Viet Nam and a return to law and order. His impromptu talk, entitled "1968 — A Year of Challenge and Opportunity," was warmly received by the hundreds of guests.

All candidates for major state offices were invited to join Illinois physicians at this special affair. Among those attending were Senator E. M. Dirksen (R.-Illinois), Senate Minority leader, and Richard Ogilvie, candidate for the Republican nomination for governor. Mayor Wes Olson of Quincy, candidate for State Auditor, also attended.

Philip Thomsen Installed As ISMS President

At the third session of the House, Philip Thomsen, Dolton, was installed as president of ISMS. In his inaugural address Dr. Thomsen cited the challenges which appear before him in this next year, but challenges not only to him but to each and every physician and to ISMS. Among these are the need for more physicians, revision of guidelines for medical school admission, and an effort on the part of physicians to speak out on socio-economic matters of vital concern to medicine. He stated that medicine itself is today a patient, on an emergency list. He called for concerted, increased effort on the part of ISMS and all physicians to answer the cry.



Philip Thomsen, (left) receives the President's Medallion from Newton DuPuy at Dr. Thomsen's installation at the third session of the House of Delegates. Dr. DuPuy now becomes trustee-at-large of the society.

Special Report Draws Praise

Dr. George Lull, Executive Administrator, presented a special 23-minute slide presentation report to the House. The report showed all the varied activities of ISMS, and showed how each function of the various councils and divisions are accomplished. This special report was lauded as a most effective portrayal of ISMS activities and services. The report will be made available to county and district medical societies in the future.

Third Annual Hamilton Teaching Award To Dr. Arthur R. Colwell

Dr. Arthur R. Colwell, Professor and Chairman of the Department of Medicine, Northwestern University, Emeritus in 1965, received the Edwin S. Hamilton Teaching Award for outstanding medical teaching. The honor is given annually by the Interstate Postgraduate Medical Association of North America in honor of Dr. Hamilton, past president of ISMS. Born in Chicago, Dr. Colwell is a graduate of Rush Medical School and taught at Northwestern from 1933 to 1965.



George F. Lull, M.D., immediate past president of the Interstate Postgraduate Medical Association, presents the Edwin S. Hamilton Teaching Award to Arthur R. Colwell, M.D. The annual plaque and cash prize is awarded to an outstanding educator in honor of the past president of ISMS.

New Executive Administrator Named

The Board of Trustees, meeting during the convention, named Roger N. White executive administrator of ISMS. The announcement was made at the second session of the House. Mr. White, a native of Pennsylvania, has served ISMS for 8 years as the Director of Legislation and Public Affairs and Assistant Executive Administrator. He succeeds Dr. George F. Lull.

Special Sesquicentennial Luncheon With Fifty-Year Club

A total of 36 physicians were inducted into the Fifty-Year Club. This club, the first of its kind in the United States, was originated by ISMS in 1937. It honors physicians who have achieved the milestone of 50 years since graduation and numbers over 500 members. The luncheon, in conjunction with the Archives Committee, commemorated the sesquicentennial of Illinois. The luncheon speaker, W. D. Snively, MD, Vice President of the Mead Johnson Company, spoke with his talk entitled "We War Perplext by a Disease Cald Milksick." As a result of this program ISMS was awarded a special citation by the Illinois Sesquicentennial Commission for outstanding contributions to the commemoration of the anniversary.

Journalism Fellowship Winners Attend Convention

Mrs. Sue Dinges of the Illinois State Register, Springfield and Mr. James Rick of the Danville Commercial News, were in attendance at the convention. They were the recipients of the Second Annual Journalism Fellowships of the ISMS. The fellowships are unique among state medical societies and encourage young science writers in achieving their goal of top notch reporting. Both recipients filed stories daily about the activities of the convention.

New Members of Board of Trustees

Elected 1st Vice President of ISMS was Dr. Casper Epsteen of Chicago. The new 2nd Vice President is Dr. Carl E. Clark of Sycamore, who retired as trustee from the 1st district. Succeeding Dr. Clark is Dr. Joseph L. Bordenave of Geneva. Elected as trustee from the 2nd district was Dr. William A. McNichols, Jr., Dixon. Dr. Joseph R. O'Donnell, Glen Ellyn was re-elected from the 11th district. Drs. Lees and Jirka were re-elected from the 3rd district.

Physicians Urged To Use Only Illinois Laboratories

The use of medical diagnostic laboratories supervised by a duly qualified physician, licensed in or by the state of Illinois was encouraged by the House approval of the Laboratory Evaluation Sub-committee report. The hazards of mailing specimens over long distances and the need for adequate Illinois inspection are of utmost importance.

Mandatory Tuberculin Testing Approved

Approval of the Report of the Tuberculosis Committee by the House encouraged all physicians to make a TTT part of the school health record of every child in Illinois. The committee recommended, that "As in Michigan and Indiana, Illinois should make the tuberculin test mandatory in all pre-school examinations."

Ad HOC Committee on IDPA Compensation Called For

An ad hoc committee or an appropriate existing ISMS committee was encouraged by the House in a resolution calling for determination of an alternate method of compensation acceptable to those physicians not wishing to accept assignments but who are willing to accept the responsibilities of the health care of public aid recipients.

Health Careers Council Support Continued

For the year 1969, the House approved the apportionment of $2 per full dues-paying member for HCCI. The funds will be taken from the Benevolence Fund.

Hospital Facilities Grouping To Be Investigated

The House resolved to cooperate with the Illinois Hospital Association and the Illinois Department of Public Health in seeking legislation amending the hospital licensure act to permit hospitals and their staffs to combine facilities where it is both feasible and desirable for the improved handling of the emergency patient.

Support Legislation On Blood And Tissue Transfer

Although legislation is already proposed in the Illinois Assembly, the House concurred with a recommendation that legislation be encouraged to make the transfer, transfusing and use of blood, blood derivitives, plasma, tissues and organs a service and not a sale.



Dancing to the music of the Mariachi Band at the President's Party, the Mexican Fiesta, were these past-presidents of ISMS. From left, Dr. and Mrs. Arkell Vaughn, Dr. and Mrs. Leo P. A. Sweeney, Dr. and Mrs. Harlan English and Dr. and Mrs. Burtis E. Montgomery. The party was preceded by the Camp Memorial Lecture given by Sen. George Murphy at the President's Dinner.

ABSTRACTS OF ACTIONS OF THE HOUSE OF DELEGATES MAY, 1968

OFFICERS AND ADMINISTRATION

Under this area in Headquarters lies the supervision of several important committees, all of which appear as "Board Committees" on the general outline. The reports of the President, Chairman of the Board, Secretary-Treasurer embody much of the important material to come before the Board in the interim between meetings of the House.

The Policy Committee, chaired by William E. Adams, presented several new policy statements to be incorporated in the Policy Manual when it is reprinted in the Reference Issue of the IMJ in the fall.

Audits and Surveys (In hospitals and nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management, should not be condoned.

Hospital Committees (Dealing with physician-patient relationship)

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes, are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

These two statements were the two which impressed the reference committee more than any of the others which were presented (a total of six which will appear in the new manual). No change was made this year in the existing statements.

The Committee to Study Committees was asked to continue its review of the responsibilities and purposes assigned to each active committee, and to keep the various Councils defined and active.

One of the most far reaching actions taken by the House was to approve the request of the COMMITTEE TO CONSIDER OSTEOPATHIC PROBLEMS, which perhaps will clear the atmosphere and make some progress possible in an area long clouded by deep-seated differences between the two professions. The Reference Committee recommended (and the House concurred) that the following statement be approved:

"Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, and if he is licensed to practice medicine and surgery in all of its branches in Illinois."

The resoluton to limit the number of terms a delegate from the ISMS to the AMA House could serve, was defeated. The Reference Committee stated that "in as much as the delegates must be re-elected every two years, adequate means for replacing delegates already exists". Also, such limitation might well deprive Illinois of the Speaker or Vice Speakership of the AMA House, since both these officers must be members of the House, elected by one of the component state societies.

The House did ask that the AMA delegation, in its yearly report to the House, "specifically speak to the point of ways to increase the effectiveness of the delegation with special reference to preparation of future members of our AMA Delegation".



Receiving an award from the Illinois Sesquicentennial Commission for its efforts in behalf of the commemoration is ISMS President Newton DuPuy. The award was presented by Mr. Newman, Director of the Illinois Sesquicentennial Commission.

FINANCES AND BUDGETS

The Society has implemented the recommendation in the 1966 Opinion Research report that data processing be instituted in various areas of society activity. During the year 1968 seventy county medical societies used the direct membership dues billing and collection service. To date, the Society has bought computer time as needed.

The committee stressed the ruling of the House that was made several years ago—that any new program of major nature must be accompanied by a suggested method of providing the necessary finances for the project.

The revolving fund set up by the IAA and the ISMS for the education of rural students interested in medicine and willing to practice in a small Illinois community operates with a capital of $230,000. Dr. Jack Gibbs and his committee conduct the investigations, make the loans, and report on the project in detail.

Funds are always needed by the Educational and Scientific Foundation to conduct programs of various nature. A "one time" donation of $45,750 was made to the Foundation by the Illinois Medical Journal, and has been earmarked for planned improvements in the IMJ.

The House specifically requested that the full $20 allocated from each physician's dues be returned to the AMA-ERF. Medical Education needs unrestricted funds more today than at any other time, and the cooperation of the five deans with the State Society has been a growing and an important phase of educational planning in Illinois.

Also, the need of the Health Careers Council of Illinois was recognized. The House recommended that the Board allocate $2 per dues paying member to this group again in 1969. In order to keep the dues structure at the same level, the Board of Trustees agreed that the $7 scheduled for the Benevolence Fund should be cut to $5, and the balance of $2 should be given to HCCI in 1969.

This holds the DUES STRUCTURE AT THE SAME LEVEL in 1969, with the distribution as follows:

Dues.....for 1969	$105.00
Breakdown:	
AMA-ERF	$20.00
HCCI	2.00
Benevolence	5.00
Reserves	8.00
Operating Fund	70.00

ECONOMICS AND INSURANCE

The Committee on Aging has developed in cooperation with the Blue Shield Plan of Illinois Medical Service, a Pre-retirement Planning Series of 13 half-hour shows to appear on WTTW, Channel 11, Chicago. The tapes will be available for other television stations in Illinois and perhaps throughout the country. The reference committee felt this a positive approach to the problem popularly referred to as the "retirement revolution".

Economics and Insurance information was reviewed carefully. The new professional liability insurance program was studied as were other policies available to members. The features which make the professional liability program of extreme interest include:

1. Coverage available to all ISMS members with no restriction on age or specialty.
2. Policies are non-cancellable without just cause.
3. Claims cannot be settled by the insuring company without the physician's consent.
4. The company and ISMS will cooperate in an educational program to show physicians how they can lessen the chances of a malpractice suit being filed against them.

The reference committee specifically urged the Society to make every promotional effort to provide an informational program to the membership.

The Relative Value Study should be revised and/or reprinted if money is available. By action of the House, this recommendation was referred to the Board for consideration.

In the area of Illinois Department of Public Aid activity, the House concurred in the reference committee recommendation that county medical societies be urged to appoint review committees (or assign this duty to an already established committee)

to act as liaison between the Illinois Department of Public Aid and local physicians. This would undoubtedly enhance communications between IDPA and the local membership. In fact, the reference committee and the House felt that the problem of communications was one of the most important areas for providing a constructive and smoothly operating IDPA program.

ISMS was asked to institute periodic instructional meetings (work-shops) for the county medical society review committees to keep them abreast of problems and changes in payment policies.

The "double standard of usual and customary fees paid by Medicare fiscal intermediaries and the usual and customary fees paid by the IDPA" came up for action. The House recommended that this double standard be discontinued even if it "requires the implementation of legislation to accomplish this end" . . .

In the area of usual and customary fees, the reference committee and the House approved this method of approach as satisfactory and as a possible solution to the problem of compensation for medical services to public aid recipients.

Unfortunately, exceptions have occurred in which IDPA has indiscriminately reduced payments without explanation. The House felt this probably due to inadequate communications and poor liaison, and suggested that when fee problems are adjudicated:

1. Appeal should be made to the IDPA Springfield office.
2. If physician and the IDPA cannot agree, the physician has the right of appeal to the advisory committee of his county medical society.
3. The final appeal is to the ISMS Usual and Customary Fee Committee.

The reference committee called the attention of the House to the fact that the Division of Vocational Rehabilitation continues to follow a fee ceiling plan inconsistent with the policy of the Society.

The House approved the recommendation that the Usual and Customary Fee Committee renew its efforts to persuade the DVR to adopt a medical payments program based on usual, customary and reasonable fees, in the interest of uniformity and consistency, and third party participation should be so based.

Many of the Society's most important programs fall within the purview of this committee's activities. Close cooperation with the various county, state and federal agencies, rulings in the area of patient care, communications with the membership, and a constant alert are prerequisites for continued success.

It was suggested that the sub-committee on cardiovascular diseases be disbanded.

Praise for the Drug Manual and the efforts expended in maintaining it were expressed. The Committee has reviewed 963 written requests for drugs not listed in the manual and more than 99% of the requests were approved.

PUBLICATIONS AND SCIENTIFIC SERVICE

In the area of scientific service many of the committees submitted progress reports upon which no specific action of the House was necessary. Except for several items considered by the Reference Committee on Finances and Budgets the report of the IMJ was included in this area. The Journal format, contents, program given in New York for the members of the advertising media, all received praise, not only from the members of the Board, but from outside sources. The "ISMS STORY—Slide-Sound Presentation" given to the House at its opening session on Sunday, was originally prepared for the advertisers at the New York reception.

The support for the AMA-ERF contribution was approved; the educational program for preceptorships supported; a medically oriented summer job program for freshmen medical students met with unanimous acceptance and will be instituted as soon as possible.

The vital and pressing importance of medical education and the Campbell report came in for discussion, and members of the Committee on Medical Education were asked to continue cooperation with the deans, encourage the establishment of an additional medical school in Illinois; work to increase the number of students in the field of medicine, and continue to emphasize the field of general practice.

LEGISLATION AND PUBLIC AFFAIRS

The brevity of the report of the Reference Committee hardly reflects the extensive activity of Dr. Siegel's Council on Legislation and Dr. Grevas' Committee on Public Affairs.

The reference committee recommended and the House concurred in the request of the Council on Legislation that the ISMS oppose a service occupation tax on drugs, whether dispensed by a physician or a pharmacist. The House recommended cooperation to develop a study of hospital costs, and requested continued vigilance in the support of good public health legislation and the defeat of bills detrimental to medicine.

The use of impartial medical testimony in malpractice cases is now authorized under the law. The House felt that additional study of this procedure should be made by the Judicial Council, and if, at any time a panel for malpractice cases is deemed desirable, then this area of activity should be placed under a separate committee with a separate panel other than that used in personal injury cases at the present time.

The outstanding work of the Committee on Narcotics was called to the attention of the House. While no action was taken, the importance of a reasonable approach to the problem of drug abuse, the use of narcotics, the full day sessions conducted by the committee, have given the ISMS the lead in this area on a national basis. Continued support of this activity was recommended.

The resolutions referred to this committee covered a wide field of legislative activity and subjects. The one controversial subject debated by the House for over two hours was the resolution asking that the Abortion Laws of the State of Illinois be revised. The resolution was not approved and a substitute resolution was tabled.

PUBLIC RELATIONS AND MISCELLANEOUS BUSINESS

The various committees reporting for review by this reference committee included several which were made as reports of progress—the Advisory Committee to Paramedical Groups, the Advisory Committee to the Health Careers Council of Illinois, the Illinois Medical Assistants, were all complimented upon their continued work and cooperation with other vitally concerned and interested groups.

The Sub-committee on Nursing received a minority report which resulted in the House approving the appointment of an Ad Hoc Committee on Nursing to examine the complex problem and report at the next meeting.

The development of the "President's Tour" approach to communication between the headquarters office and the county society was praised highly. This utilization of the time and efforts of the officers of the Society has resulted in a better understanding of various problems wherever these tours have been held.

Many and varied activities exist within the Public Relations Committee—Journalism Awards which have received outstanding appreciation by the television, radio and press; the Journalism Fellowship which permits two young science writers to attend our annual convention; Dr. SIMS and the appearances he makes—on the air, in the press, and at the state fair; Community Health Week, which has become a national affair; physicians' placement service which has aided physicians in finding compatable areas in which to practice, and areas to find medical personnel willing to fill the local need. Medicine and Religion will institute an annual award similar in nature to the Journalism Award which has proven to be so popular.

The House approved a resolution urging that protection be given medical treatment facilities, all patients and hospital personnel in any civil disorder. A resolution asking that the AMA consider establishing "a spokesman of continuing tenure" was referred to the Board for further study.

The changes made in the Bylaws this year were minor, and were introduced to clarify the Council setup developed by the major changes made by the 1967 House of Delegates. The efficiency of this method of committee appointment and function is proving itself in time saved for the Board, and in the ability of the Chairman of the Board, through the Committee on Committees, to combine and keep current, society committees and their functions. A period of several years may be necessary for some areas to recognize and utilize the advantages provided.



Enjoying themselves at the President's Dinner were Dr. and Mrs. Maurice Hoeltgen, Speaker of the House, and Dr. and Mrs. Paul Sunderland, Vice-Speaker.



Sen. George Murphy (R.-Calif.) Shares some views with Dr. Theodore Grevas, Rock Island, Chairman of the ISMS Public Affairs Committee.

ACTIONS ON RESOLUTIONS
1968 HOUSE OF DELEGATES

Number	Introduced by	Title	Action
68M-1	Kane County	Accounting to House for use of AMA-ERF Funds	NOT adopted
68M-2	Kane County	Legislation re Human Tissue as a medical service	Considered w/#30—NO action
68M-3	DuPage County	Preceptorship Program for Junior-Seniors	Adopted
68M-4	DuPage County	Summer Job Programs for Freshman Medical Students	Adopted
68M-5	Jackson County	Legislation re consolidation of emergency room services	Substitute resolution adopted
68M-6	Madison County	Legislation re Physical exams for pre-school children	NOT adopted
68M-7	Kane County	Term of Office of AMA delegate	NOT adopted
68M-8	Vermilion County	Legislation re Practice without a License	NOT adopted

68M-9	DuPage County	Funds for Medical Education and ISMS Foundation	Subs. resolution adopted
68M-10	DuPage County	Support for per-student subsidy and Legislation to supply	Adopted as amended
68M-11	Robt. R. Hartman	Memorial to John Rendock, MD	Adopted
68M-12	Philip G. Thomsen	Fiscal Year of Woman's Auxiliary	Adopted; to AMA
68M-13	Saline-Pope-Hardin	Prescription forms for use in IDPA cases	NOT adopted
68M-14	Will-Grundy County	Study of Illinois Mental Health Dept.	NOT adopted
68M-15	Will-Grundy County	Corporate Practice of Medicine No. 1	Adopted as amended; to Board of Trustees
68M-16	Will-Grundy County	Corporate Practice of Medicine No. 2	NOT adopted
68M-17	Will-Grundy County	Corporate Practice of Medicine No. 3	NOT adopted
68M-18	Edward A. Razim	JCAH Ruling on Use of Externs, Clarification of	Adopted as amended; to AMA
68M-19	James P. Campbell	Protection of Medical Personnel in times of Civil Disorder	Adopted
68M-20	Morgan Myer for Committee on Medical Education	Use of Externs in Hospitals	NOT adopted
68M-21	Coles-Cumberland	Usual and Customary Fees for IDPA cases	NOT adopted
68M-22	Aux Plaines Branch Delegates—CMS	Financial Support for HCCI	w/resolution # 28 Subs. resol. approved
68M-23	Jackson County	Use of panel system of IMT in malpractice suits	NOT adopted
68M-24	Winnebago County	Legal protection for medical profession working in mass immunization programs	NOT adopted
68M-25	Winnebago County	Requirement under Medicare that MD visit extended care every 30 days	NOT adopted
68M-26	Winnebago County	Mandatory monthly nursing home visits under JCAH ruling	Adopted; to AMA
68M-27	Winnebago County	IDPA levels of reimbursement and Adjudication	NOT adopted
68M-28	Bond County	$2 per member for HCC from AMA-ERF and assigned again in 1968	w/Res. #22 and subs. adopted
68M-29	Lake County	Spokesman for AMA	Referred to Board of Trustees; Adopted
68M-30	DeKalb County	Blood and Blood Derivities	Considered w/Res. #2. Approved
68M-31	Robt. Hartman	Statutes re: Abortion	NOT adopted
68M-32	Clark County	IDPA method of compensation	Substitute resolution adopted
68M-33	Rock Island	Public Affairs at AMA level	Adopted; to AMA
68M-34	Del. from SS-CMS	Neutrality during Civil Disturbances	NOT adopted



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SOCIO ECONOMIC news

A service of the Public Relations and Economics Division

Ambulance Service Cutbacks Arouse ISMS Concern

Funeral directors in downstate Illinois are phasing out of ambulance service because of the prohibitive costs of sophisticated equipment and attendant-training. While police and firemen largely conduct such service in Chicago, morticians have been handling 80 per cent of it downstate. Several solutions are possible, including subsidization of funeral directors or the formation of ambulance services by hospitals, state agencies or private agencies, says Dr. Max Klinghoffer, chairman of the ISMS Committee on Disaster Medical Care. He adds that a combination of solutions may prove necessary, including use of civil-defense personnel and new methods of transportation. For example, English-style vans would be economical, and helicopters would be flexible, particularly in the face of traffic tieups. The ISMS House of Delegates, at its May meeting, urged "an all-out effort" to keep ambulance service abreast of modern needs.

ISMS Keogh Plan A Leader in Stock Fund Growth

The stock fund of the ISMS tax-qualified retirement (Keogh) program was a leader in its field last year with a 27 per cent growth, Medical Economics reports. Of the 17 other funds sponsored by national, state and local medical associations, only one (Colorado's) chalked up a larger growth. Average gain in all the Keogh funds was 21.1 per cent. The ISMS program's Stein Roe & Farnham Stock Fund outstripped all but two of the other funds from 1964 through 1967, with a 58.9 per cent growth. Furthermore the fund is no-load, enhancing the relative net gains, administrator Paul H. Robinson, Jr., noted. Earnings on the group annuity portion of ISMS' Keogh program ran 4.94 per cent last year on total investments, and are exceeding 5 per cent this year, he added. ISMS expects to double its Keogh enrollment by December 31 because of the new tax incentives provided by Congress.

Reconciliation Sought in Medicare, IDPA Fees

Delegates to the ISMS annual meeting called for elimination of the "double standard" in the usual and customary fees paid by Medicare fiscal intermediaries and the Illinois Department of Public Aid. This step should be taken even if it requires legislation, the recommendation stated. Drafters of the recommendation feel that Medicare fee payments are more considerate and consistent than those paid by IDPA.

Delegates Ask Improvements in Liaison With IDPA

Delegates also approved recommendations calling for better liaison between county medical societies and IDPA, and between the state and county offices of IDPA. They urged county medical societies to form review committees to act as liaison between the state agency and local physicians. Questioning the "efficiency and effectiveness" of communications between the IDPA's state and county offices, the ISMS suggests that "constructive efforts be made to improve those areas in which communications are deficient."

Research Pinpoints Relation of Alcohol to Accidents

Drivers with 0.10 per cent of alcohol in their blood are more than six times as likely to cause accidents as non-drinkers, while those with 0.15 levels are 25 times as likely. Drivers with 0.04 levels are no more accident-prone than non-drinkers. These are the findings of Dr. Robert F. Borkenstein, chairman of Indiana University's Department of Police Administration, and R. F. Crowther, as reported in the Journal of American Insurance. The ISMS last year helped put through a state law reducing from 0.15 to 0.10 per cent the level at which a driver is presumed to be under the influence of liquor; 42 states still have the 0.15 yardstick. The insurance magazine noted that a person's weight influences his blood-alcohol level. A person weighing 140 pounds reaches the 0.10 level after four highballs containing 100-proof liquor; a 200-pound man does not reach this percentage until the sixth highball.

SAMA Project in Ghettos May Extend to Illinois

The Student American Medical Association hopes to extend to Illinois the pilot health-information project it is launching in poorer neighborhoods of Kansas City, Kan. "We have every hope of extending it to Chicago, East St. Louis and other Illinois cities," said Russell F. Staudacher, SAMA executive director emeritus. But such action, he noted, is "contingent on support from voluntary health agencies and other groups in the private sector of the economy." A $39,000 grant from the AMA enables the Kansas City project to operate on a year-around basis. Medical students will establish contacts with residents of indigent neighborhoods and tell them what medical facilities are available. A basic goal is to help the students learn and evaluate the health-care problems of the poor. Results of the project will be weighed at SAMA's 1969 convention in Chicago.

Colorado Abortion Facts May Interest Illinoisans

About the time that delegates to the ISMS annual meeting rejected proposals for broadening the Illinois abortion law, Colorado tallied some results of its own liberalized statute. Psychiatric reasons accounted for 123 of the 227 therapeutic abortions reported in the first 11 months since the Centennial State's law took effect. Medical Tribune said other reasons included medical risk, 28; rape, 21; rubella, 13, and suicide, 2. No statement was given in 40 cases. Sixty-five of the patients were from outside the state.

IDPA Director Swank Gets Public Service Award

Harold O. Swank, IDPA director, has been presented with the Distinguished Public Service Award by the Central Illinois chapter, American Society for Public Administration.

Chiropracter Plea to IDPA Opposed by Advisory Group

The Illinois Chiropractic Society has asked IDPA to include chiropractic in the services provided public-assistance recipients, on the ground that its practitioners are licensed under the Illinois Medical Practice Act. The question now, according to IDPA, is whether or not such service is "essential medical care." The ISMS Medical Advisory Committee to IDPA asserts it is not.

By DON B. FREEMAN

Clinics for Crippled Children

Twenty one clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will conduct fourteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August 1 Lake County Cardiac—Victory Memorial Hospital
August 7 Carlinville—Carlinville Area Hospital
August 7 Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital
August 7 Hinsdale—Hinsdale Sanitarium
August 8 Springfield General—St. John's Hospital
August 9 Chicago Heights Cardiac—St. James Hospital
August 9 Evanston—St. Francis Hospital
August 13 East St. Louis—Christian Welfare Hospital
August 13 Peoria General—Children's Hospital
August 14 Champaign-Urbana—McKinley Hospital
August 15 Rockford—Rockford Memorial Hospital
August 15 Elmhurst Cardiac — Memorial Hospital of DuPage County
August 20 Belleville—St. Elizabeth's Hospital
August 21 Chicago Heights General—St. James Hospital
August 22 Effingham Rheumatic Fever & Cardiac—St. Anthony's Memorial Hospital
August 22 Bloomington—St. Joseph's Hospital
August 23 Chicago Heights Cardiac—St. James Hospital
August 27 East St. Louis—Christian Welfare Hospital
August 27 Peoria General—Children's Hospital
August 28 Springfield Cerebral Palsy (P.M.)—Diocesan Center
August 28 Aurora—Copley Memorial Hospital

More than five million veterans visit Veterans Administration outpatient clinics in a year.

Half of the physicians in the U. S. receive some part of their training in the Veterans Administration, the largest medical complex in the world.

OBITUARIES

***Dr. George B. Bradburn,** Chicago, died May 7 at the age of 58. He had been senior attending physician of the department of obstetrics and gynecology at Wesley Memorial Hospital and assistant professor at the Northwestern University Medical School.

***Dr. Charles K. Carey,** 73, of Rushville, a retired physician who practiced medicine for 34 years, died May 6. He was a former secretary of Schuyler County Medical Society.

***Dr .William L. Fishbein,** 65, of Lincolnwood, a medical director of health services for the Chicago Board of Health, died May 23.

***Dr. Clare A. Garber,** 95, a Decatur physician for more than 60 years, died May 16. She was a member of the American Institute of Homeopathy, American Medical Women's Association, Pan-American Medical Women's Alliance and a member of ISMS Fifty-Year Club.

***Dr. Joseph L. Gonzalez,** 49, Olympia Fields, died May 2. He was a resident physician at South Suburban Hospital.

***Dr. Samuel Governale,** 69, Chicago, a physician for more than 42 years and former chief of surgery at St. Bernard's Hospital, died May 11.

***Dr. Harry D. Grossman,** 69, Chicago, died April 21. He was a physician for 47 years, on the staffs of Michael Reese and Woodlawn Hospitals.

***Dr. Ewald E. Hermann,** 73, a retired Highland physician and surgeon, died May 22. He was a veteran of World War I, a member of the International College of Surgeons, and a member of ISMS Fifty-Year Club.

***Dr. Harold L. Klawans,** Chicago, died April 28 at the age of 65. He had been the chief medical officer of the Chicago Board of Health, on the faculty of the University of Illinois Chicago Circle campus and on the staff of Michael Reese Hospital.

***Dr. Nikolaus Koenig,** Chicago, died May 8 at the age of 40.

Dr. G. E. Linden, 81, of Highland Park, was a practicing physician for 45 years.

***Dr. Ray Logan,** 79, a Galena physician and benefactor for over fifty years, died April 24. He was former mayor of Galena, past president of the Jo Daviess County Tuberculosis Association, former president and secretary of Jo Daviess County Medical Society, a member of the Galena Board of Education and a member of ISMS Fifty-Year Club.

***Dr. George W. Moxon,** 72, Chicago, died May 5. He was a past president of the University of Illinois College of Medicine Alumni Association.

***Dr. Alfred Nienow,** 77, a Summit physician and surgeon for more than 48 years, died May 16. He was a member of ISMS Fifty-Year Club.

***Dr. Willis J. Potts,** 73, the children's surgeon who perfected the "blue baby" heart operation, died May 5. He was a past president of the Chicago Heart Association and was listed among the 100 leading Chicagoans, as well as one of the 10 Leaders of American Medicine.

***Dr. John D. Scouller,** 92, a Pontiac physician and surgeon for 45 years, died April 11. He was past president of Livingston County Medical Society, a member of Alpha Omega Alpha.

***Dr. V. B. Stanford,** 79, Illiopolis, who practiced general medicine for 42 years, died May 11. He was a member of ISMS Fifty-Year Club.

***Dr. Pauline D. Stepleton,** 61, Glen Ellyn, died April 25. She was a former staff member at Michael Reese Hospital and Medical Center.

*Indicates member of Illinois State Medical Society.

FILM REVIEW

A fast and accurate method for detecting elevated Phenylalanine levels in the first few days of a newborn baby's life is described in detail in an 18-minute, 16 mm., color film, "Early Detection of PKU in the Hospital Nursery." The system was developed by Dr. Robert Guthrie, Children's Hospital, Buffalo, N. Y. and is demonstrated with the cooperation of the State University of New York at Buffalo and the hospital. A grant from the Children's Bureau of the Department of H.E.W. made the film possible. It was produced by Designs For Medicine and is available at a rental fee of $9 from the International Film Bureau, 332 S. Michigan Ave., Chicago, 60604.

Do you have patients who try to hide frustration behind conformity?

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Sponsored by the ISMS Committee on Religion and Medicine to acknowledge contributions over the past year by an Illinois physician and clergyman utilizing the skills of the profession cooperatively to promote total patient care. Eligibility restricted to physicians licensed to practice medicine in Illinois and clergymen of all faiths residing in the state.

DEADLINE FOR ENTRIES AUGUST 31, 1968

Send name, address, and 200-word summary of nominee's achievements to:

ILLINOIS STATE MEDICAL SOCIETY
COMMITTEE ON RELIGION AND MEDICINE
360 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

State winners—one physician and one clergyman—will be honored at the ISMS Board of Trustees dinner meeting in October.

Medical Scholarships for Negro Students

Dr. John C. Troxel, President of National Medical Fellowships, Inc., and Senior Vice-President, Blue Cross-Blue Shield, announced today that the largest number of scholarships and grants-in-aid have been awarded for 1968-69 since the organization began offering assistance to Negroes in medicine. A total of $190,000 was awarded to 134 Negro students for study in 55 U.S. medical schools. The awards, ranging from $900 to $2,000 a year, were made to 117 men and 17 women.

Ten outstanding Negro college students have been awarded four-year medical scholarships with awards averaging $8,000 each. These top students are the recipients of the coveted National Medical—Sloan Foundation Scholarships, the highest awards made by National Medical Fellowships, Inc. to entering medical students. Winners for 1968-69 will study at the medical schools of Harvard University, University of Michigan, Yale University, The Johns Hopkins University, Columbia University, University of Florida, University of California at San Francisco, Einstein Medical College, Tulane University, and Emory University.

Through the National Medical — Sloan Foundation Scholarship program which is administered by National Medical Fellowships and financed by grants which have exceeded $600,000 from the Alfred P. Sloan Foundation, 98 students have entered medical schools since 1960.

Dr. Troxel also stated that through a 3-year grant from The Woods Charitable Fund, Inc. of Chicago, seven young women will study medicine at the medical schools

of Louisiana State University, Case-Western Reserve University, State University of New York, Howard University (2), University of Rochester, and Albany Medical College. In announcing the grant, Dr. Troxel said: "I am very pleased that increased attention is being given to opportunities for Negro women in medicine. Well over 50% of Negro college students are women, but less than 10% of the Negro medical students are women. It is estimated that at present less than 800 Negro students are enrolled in all four classes of U.S. medical schools. The country would benefit greatly by fully exploring the potential of Negro women for medicine."

Other foundations providing support for National Medical Fellowships, Inc. are: Charles A. Frueauff Foundation, Nathan Hofheimer Foundation, New York Foundation, Gustavus and Louise Pfeiffer Research Foundation, Robert R. McCormick Foundation, Shell Companies Foundation, and the Reader's Digest Foundation.

National Medical Fellowships, Inc. of 3935 Elm Street, Downers Grove, Illinois, is a non-profit organization which provides assistance to Negroes for education and training in medicine. Since its organization in 1946, it has awarded $1,900,000 to assist 544 Negroes with their medical education and careers.

Develop Photographic Method of Detecting Radium Leaks

A low-cost photographic method for detecting leaks in sealed radium capsules and needles with greater speed than can be achieved with currently used techniques has been developed by the Public Health Service's National Center for Radiological Health.

The method is designed to facilitate testing sealed radium sources with sufficient frequency to insure discovery of leaks before radioactive contamination is spread.

The photographic leak detection technique, as developed in the Center's Southeastern Radiological Health Laboratory at Montgomery, Ala., requires only about six minutes for film exposure and print processing. As long as 24 hours may be needed for methods now generally used.

The photographic technique can be employed to detect point sources of leaking or exposed radium salts in quantities as low as 500 picocuries. Detection of this low level is possible in sources having a total strength of up to 50 milligrams of radium.

Development of the photographic detection method primarily was the work of Dr. Paul H. Bedrosian, Chief of the Radium Technology Unit at the Southeastern Radiological Health Laboratory.

"The new technique represents a safe, effective system which can be used easily and at relatively little cost to protect physicians, patients, and the general public against a significant source of unnecessary radiation exposure," said James G. Terrill, Jr., Director of the National Center.

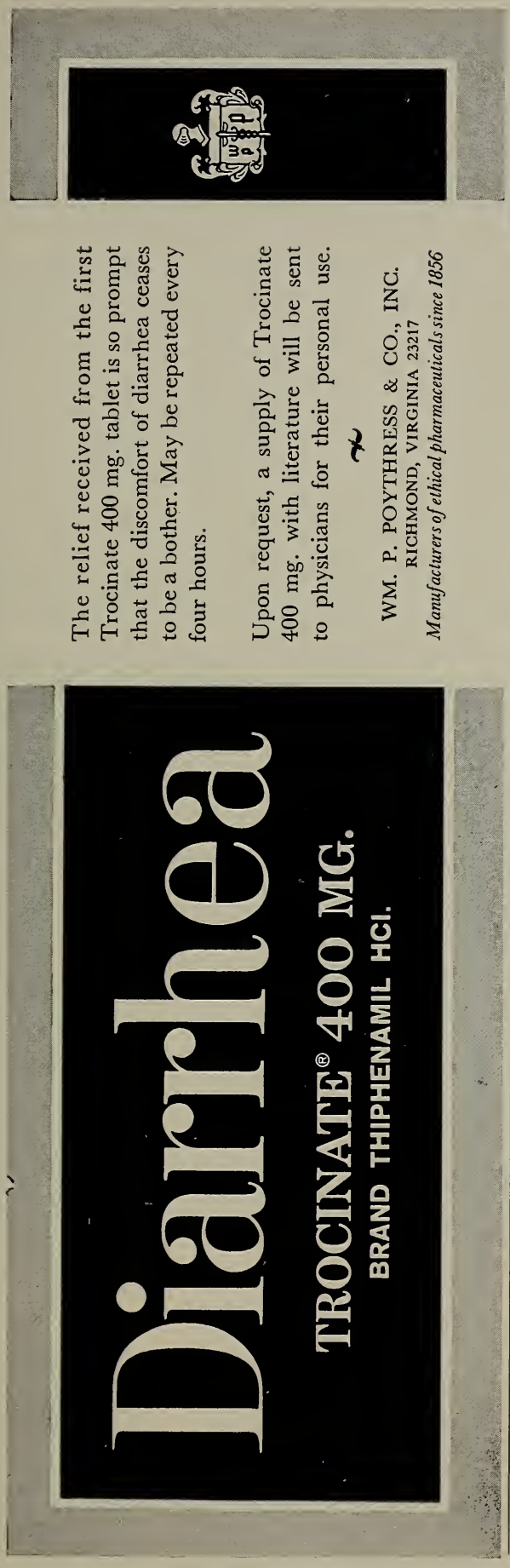
"It should be emphasized that leaks from radium capsules or needles often cannot be detected visually," Mr. Terrill said. "Many sealed sources which appear to be structurally sound, leak invisible and hazardous radiations as badly as obviously broken ones."

The essence of the new detection technique lies in the ability of radiations of alpha particles to interact with a zinc sulfide scintillator to produce light. Registration of the light on high-speed photographic film shows radium capsules or needles to be leaking, since alpha particles cannot penetrate unfractured walls of a sealed source.

Two film exposures are made for each detection procedure. In one exposure, a shield is used which prevents alpha particles from interacting with zinc sulfide but does not prevent passage of beta and gamma radiations. These, therefore, interact with the scintillator. The resulting light is focused through a lens with a well-defined image.

The shield is removed for the second picture so that light from alpha, beta, and gamma interactions with zinc sulfide are registered on film. Comparison of the images on the two films shows the alpha contribution and, therefore, the presence of a leak.

Investigators at the Southeastern Radiological Health Laboratory have found that the photographic method can be used to detect leaks or contamination at various points along the lengths of radium sources. The technique also can be employed to distinguish among sources containing varying amounts of radium and to detect radioactive contamination picked up by wiping a suspected area.



NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a preciously introduced product.

NEW SINGLE CHEMICALS

ANTIHEMOPHILIC FACTOR (Human), METHOD FOUR Biological ℞
Manufacturer: Hyland Laboratories
Nonproprietary Name: Antihemophilic factor, human (factor VIII, AHF, AHG)
Indications: Classical hemophilia (hemophilia A); patients with acquired factor VIII inhibitors.
Contraindications: None known.
Dosage: Must be individualized.
Supplied: Dried powder with diluent—10 cc. vial, 300 and 450 AHF units; 30 cc. vial, 900 AHF units

IMURAN Renal homotransplants ℞
Manufacturer: Burroughs Wellcome & Co.
Nonproprietary Name: Azathioprine
Indications: Adjunct for the prevention of rejection in renal homotransplants.
Contraindications: Hypersensitivity to the drug.
Dosage: 3 to 5 mg./kg./day, orally. Must be individualized.
Supplied: Tablets—50 mg., bottles of 100.

DUPLICATE SINGLE PRODUCTS

CHLOROPTIC Eye preparation ℞
Manufacturer: Allergan Pharmaceuticals
Nonproprietary Name: Chloramphenicol
Indications: Bacterial conjunctivitis and other superficial ocular bacterial infections caused by organisms sensitive to chloramphenicol.
Contraindications: Hypersensitivity to the drug.
Dosage: One or two drops q.4h., day and night for the first 72 hrs. Therapy should be continued for 48 hrs. after an apparent cure has been attained.
Supplied: Plastic dropper bottles—7.5 cc., 5 m./cc.

T-I-GAMMAGEE Biological ℞
Manufacturer: Merck Sharp & Dohme
Nonproprietary Name: Tetanus immune globulin, human
Indications: Passive tetanus prophylaxis.
Contraindications: None mentioned.
Dosage: Adults—250 units, i.m.; Children—4 units/kg. body wt., i.m.; Must not be injected intravenously.
Supplied: Disposable syringe of 250 units.

(Continued on page 100)



Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reductio

Magna cum depression



For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

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Tofrānil could be her commencement, too.

Tofrānil® Geigy
imipramine hydrochloride

in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

nd/or addition of a tranquilizer or emporary discontinuation of the drug, pileptiform seizures, orthostatic ypotension and substantial blood ressure fall in hypertensive patients, urpura, transient jaundice, bone marow depression including agranulocyosis, sensitization and skin rash ncluding photosensitization, eosinophilia, and mild withdrawal symptoms n sudden discontinuation after proonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in usceptible patients and in those sing anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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New Pharmaceutical Specialties

(Continued from page 97)

COMBINATION PRODUCTS

OVRAL Progesterone/estrogen comb. ℞
Manufacturer: Wyeth Laboratories
Composition: Nodgestrel 0.5 mg.
Ethinyl estradiol 0.05 mg.
Indications: Oral contraception.
Contraindications: Thrombophlebitis, or history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of breast or genital organs, undiagnosed vaginal bleeding.
Dosage: Beginning on day five of menstrual cycle, one tablet daily for 21 days. Skip 7 days before starting next cycle.
Supplied: Tablets—21 per dispenser, packets of 6.

NEW DOSAGE FORMS

LASIX Injection Diuretic—Other ℞
Manufacturer: Hoechst Pharmaceutical Co.
Nonproprietary Name: Furosemide
Indications: Edema associated with congestive heart failure, liver cirrhosis, and renal disease including the nephrotic syndrome. To be used when oral administration is not possible.
Contraindications: Anura, hepatic coma, electrolyte depletion, hypersensitivity to the drug. Therapy should be discontinued if increasing azotemia and oliguria occur during treatment of progressive renal disease.
Dosage: 20 to 40 mg., i.m. or i.v. A second dose may be given two or more hours after the first. Not to be used in children.
Supplied: Ampuls—2 cc., 10 mg./cc.

National VD Survey

On July 1, 1968, all practicing physicians in the U.S. received a questionnaire asking the number of cases in infectious syphilis, other stages of syphilis and gonorrhea treated by them from April 1 through June 30, 1968.

This survey, entitled, "National Survey of VD Incidence," is a repeat of a similar 1962 poll and is sponsored jointly by the American Medical Association, the American Osteopathic Association, the National Medical Association, American Social Health Association in cooperation with the Public Health Service.

Current estimates show that VD is infecting Americans at the alarming rate of 1,100,000 cases a year and is now the nation's most urgent communicable disease problem. Indications are that private physician reporting has increased considerably since the 1962 survey, which showed the level of reporting to be only 11% of the infectious cases treated. The 1968 survey should determine the extent of increase.

The questionnaire card requires no signature and replies of individual physicians will *not* be identified by name.

Post-Pericardiotomy Syndrome

(Continued from page 58)

these syndromes is the scar in the myocardial tissue and pericardium. More precisely the nerve lesions in these scars—neuroma or nerve ending hyperplasio—can explain the different signs or different aspects of the syndrome, and this is consistent with the present role of the nervous system in psycho-somatic medicine. In other words, this syndrome may be similar to the phantom syndrome of amputation neuroma. This hypothesis explains also why the symptoms develop after a latent period. We consider that in general we must pay more attention to the role of visceral scars in the pathogenesis of diseases.[2]

If some authors have implicated the trauma of surgery (Wood, 1954, January et al. 1954, Elster et al. 1954, Papp and Xion, 1956, Bercu 1953, Julian et al. 1954, Larson 1957, quoted by H. Geld[5]) this trauma may act through the scars they produce.

The concept of neurogenic origins inspired us to give her vitamins B_1 and B_6 —in addition to her other cardiac treatment —with good results.

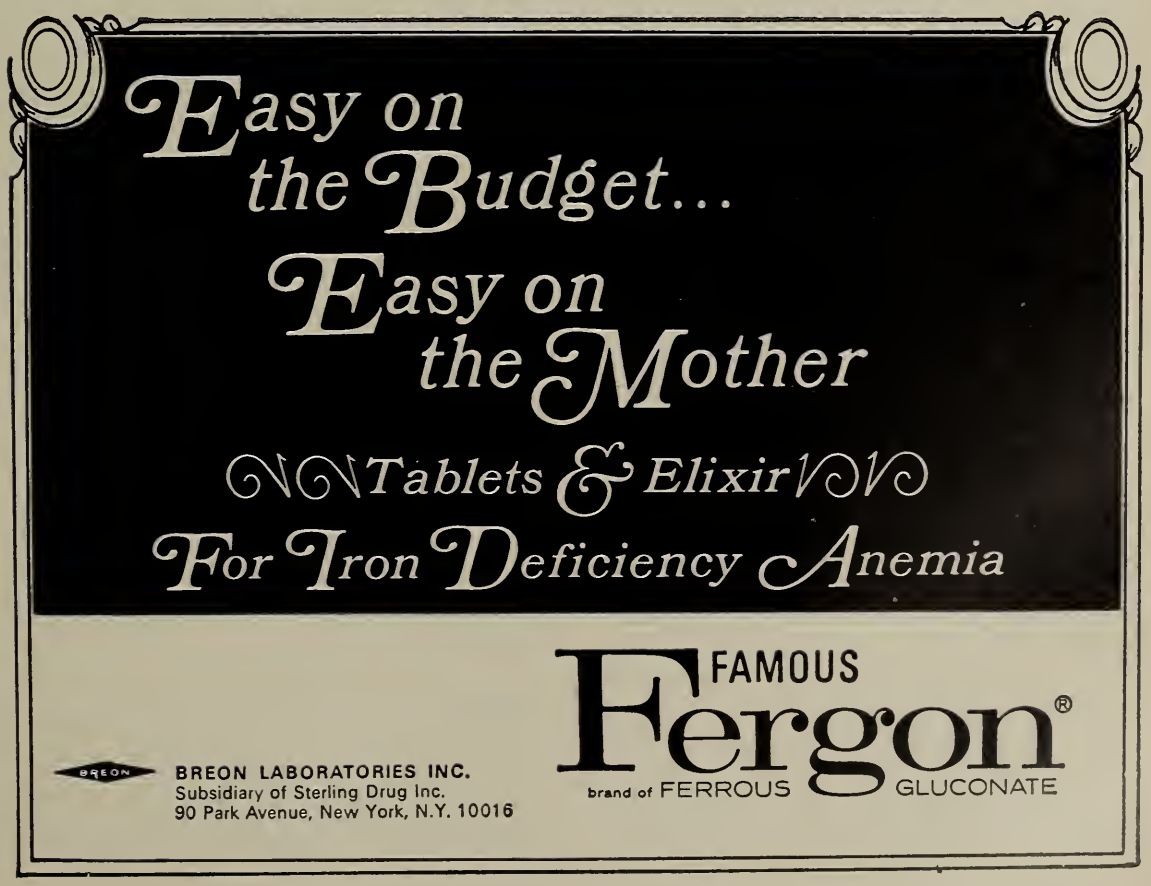
Conclusion

We consider that there is a similarity between the pathogenic mechanism of the post-pericardiotomy syndrome and phantom syndrome of amputated neuroma.

References

1. Buchanan, W. W.: Chicago Medicine, 1965, February 20, Vol. 68 No. 4.
2. Cohen, E. J.: Acta Gastro-Enterologica, Belgica, 1959, Fasc. 2, Page 95.
3. Drusin, M. L., Engle, M. A. Hagstrom, J.W.C. and Schwartz, M.S.: The New England Journal of Medicine, 1965, March 25, Vol. 272, No. 12.
4. Fudenberg, H. H.: Hospital Practice, 1968, January, Vol. 3, No. 1.
5. Geld, H. van der: The Lancet, 1964, September 19, Vol. II, No. 7360.
6. Ito, T., Engle, M., and Goldberg, P. H., 1958, Circulation 17:549.
7. Soloff, L. A., Zaruchni, J., Janton, O. H., O'Neil, T.J.E., Glover R. P., 1953, Circulation 8:481.

President Johnson ordered the establishment of U. S. Veterans Assistance Centers in 20 major cities. He told Congress he wants a veteran to receive in one place "personal attention and counsel on all the benefits the law provides him—from housing to health, from education to employment."



THE VIEW BOX

(Continued from page 36)

DIAGNOSIS: ACUTE TRAUMATIC RUPTURE OF THE LEFT HEMIDIAPHRAGM.

The diaphragm is occasionally injured by blunt abdominal trauma. It may be lacerated by a fractured rib end or may rupture from sudden violent increase of the intra-abdominal pressure. The left half of the diaphragm is by far the most commonly involved. When the left leaf ruptures adjacent abdominal viscera enter the thorax. Most commonly these are the stomach, splenic flexure, small bowel, spleen and omentum. The four cardinal signs of traumatic diaphragmatic hernia are (1) an arch like shadow resembling an abnormally high diaphragm; (2) gas bubbles, homogenous densities or other abnormal markings extending about the anticipated level of the normal diaphragm; (3) shift of the heart and mediastinal structures (frequently present and dependent upon the volume of viscera and fluid encroaching on the thoracic space); (4) disc or plate like atelectasis in the lung base. Fig. 1 demonstrates all these findings. The diagnosis can be definitely made with the insertion of a gastric tube which will show the stomach herniating upward. (Fig. 2). The additional use of barium or gastrografin will further help in the diagnosis (Fig. 3) and eliminate the possibility of confusing this entity with eventration.

Complications which can occur with this condition are incarceration of the hernia which can be suspected if the barium stops at the herniated segment and does not enter the stomach. If the colon is incarcerated the barium enema will abruptly terminate at the level of the splenic flexure. Associated laceration of the spleen will be accompanied by hemorrhage into the thoracic and peritoneal cavity. The use of pneumoperitoneography is valuable and can be diagnostic in demonstrating a tear in the diaphragm following the insertion of 50 cc. of 100% carbon dioxide in the peritoneal cavity. If a rent is present in the diaphragm the carbon dioxide will enter the thorax and produce a small pneumothorax.

At surgery our patient demonstrated a 7-inch laceration of the muscular and tendinous portions of the left hemidiaphragm. There was a laceration of the spleen. Part of the stomach and omentum were up in the left thoracic cavity. The colon was in its normal location.

Reference:

Nelson, James F. The Roentgenologic Evaluation of Abdominal Trauma. *Rad. Clinics of N. Amer. Vol. 4* (2) :415-431. Aug. 1966.

Chemical Discovery May Reduce Pain

Certain types of brain damage in animals have been reversed by chemicals in experiments at The University of Chicago. Under the direction of John A. Harvey, Associate Professor of Psychology and Pharmacology, damage caused by induced lesions in the brains of rats has been reversed through stimulation of production of serotonin, a natural brain chemical.

In his research sponsored by the U.S. Public Health Service, Harvey has created small lesions in rat brains which reduced the animals' tolerance to pain. By carefully studying the brains of such rats, he found the lesions had also reduced the amount of serotonin in the front of the brain. By injecting a serotonin precursor, a chemical which would induce the production of serotonin, the rats returned to their normal pain tolerance level.

Harvey and his co-workers have also given the rats a drug which reduces serotonin in the brain and causes decreased tolerance to pain. By injecting the serotonin precursor and inducing production of the chemical in the brain, he was able to overcome this effect of the drug.

Although clinical application of this knowledge to humans is in the distant future, Harvey is now testing his knowledge on larger animals. Perhaps some day it will be possible to inject humans with chemicals such as the serotonin precursor to build up thresholds of pain, overcome brain damage and guard against central nervous system disease.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are urged to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

CLINTON COUNTY: Trenton; population: 2,200. Trade area 7,000. One physician; second physician died recently; need replacement. Nearest hospital at Breese, 8 miles and Highland, 11 miles. St Louis 35 miles. Financial assistance can be arranged. Drive underway to raise funds for a medical facility. Predominant nationality: German. Agricultural and industrial area. Five Protestant and Catholic Churches. Grade and high schools. Golf courses and pools nearby. Carlyle Reservoir, now under construction, will result in large increase in population. For details contact Mr. Leroy Zimmermann, 579 W. 4th St., Trenton. Phone 224-7166 or 224-9258.

DEKALB COUNTY: Kirkland; population: 1,000. Trade area, 4,500. Nearest doctor eight miles. Nearest hospitals at Belvidere and Sycamore 12 and 15 miles. Nearest large city, 25 miles—Rockford. One prescription drug store. Sources of income: agriculture and industry. Churches: Lutheran, Methodist. Grade and high schools. Town supported two physicians for many years. Modern type medical building recently erected as suggested by Sears Foundation. For copies of economic survey made by Sears and details contact Mr. Edwin L. Johnson, 500 S. 5th St., Kirkland 60146.

DOUGLASS-PIATT COUNTY: Atwood; population 1,500. Trade area, 4,000. Only physician died July, 1965. Nearest physician, six miles. Nearest hospital at Tuscola, eight miles. Nearest cities, Decatur, 30 miles, and Champaign, 29 miles. Office space available. Financial assistance if desired. Sources of income: agriculture and industry. Four churches; grade and high school. Adequate recreational facilities within eight miles. For details contact: Mr. Vernon Cordts, Secretary, Chamber of Commerce, Atwood, phone 3321; or George Baldridge, P.O. Box 22, Atwood.

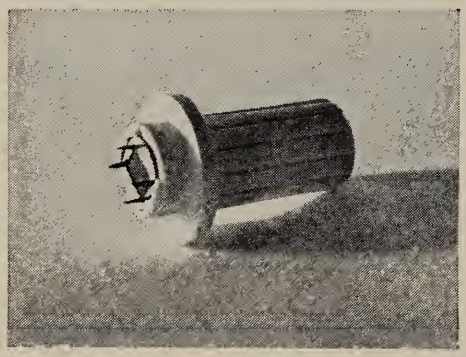
DUPAGE: Glendale Heights; population: 7,440. Nearest physicians at Glen Ellyn and Wheaton, three or four miles. Nearest hospital at Winfield. Two prescription drug stores. Office space available in shopping plaza. Predominant nationality: Polish and Italian. Churches: Baptist, Catholic, Faith Congregational and Lutheran. Seven grade schools. High school to be built. Nearby country clubs with golf courses. Very fast growing area. For further information contact: Mr. John Williams, 23 W. 458 North Ave., Wheaton. Phone: Mo 5-1960.

EDGAR COUNTY: Hume; population: 450. Trade area: 2,500. No resident physician; nearest at Chrisman, Newman, Paris and Danville, six to 40 miles. Nearest hospital at Paris, 25 miles, 75 beds. Hume Lions Club anxious to help a physician become established. Agricultural community. Churches: Catholic, Methodist, and First Christian. Three miles to consolidated high school; bus service. For further information contact: Mr. Sam Cohen, 118 Front St., Hume. Phone: 70.

EDGAR COUNTY: Paris; population: 13,000. Trade area, 60,000. Immediate opening in Medical Center Clinic, established in 1958; seven physicians in group, including three GPs, internist, surgeon and radiologist. Salary first year. Opportunity for partnership after 5 years. New air-conditioned building with lab, EKG, X-ray and library next door to hospital. Sixteen physicians in community including 13 GPs. Paris Hospital with 75 beds. New 120 bed hospital. Eighteen churches, grade and high schools. Eastern Illinois University 25 miles and Indiana State University 25 miles. Excellent golf course. For details contact: J. M. Ingalls, M.D. Phone: 5-0514, Paris.

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Surgical Grand Rounds

(Continued from page 56)

centric or irregular, as Dr. Shields has mentioned, with a thickened irregular edge, one must wonder if the abscess was prefaced by a malignant process rather than infection.

Dr. Thomas Shields: I might add that there are two other conditions that may result in abscess formation. One is Klebsiella pneumonia which causes gangrene of the involved lobe which will evacuate as an abscess. And then lastly we must consider the staphlococcic abscesses that are encountered in the young child and the debilitated adult. These result probably on an embolic basis from bacteremia in these ill patients. In patients which the staphlococcic abscess or where abscesses are primary the cure rate is relatively good. When they are associated with severe disease such as nephritis, leukemia, etc. the outlook is very dim. As far as the etiology in the patient under discussion, I believe it was probably a chronic pneumonia that became necrotic and evacuated and then filled in with inspissated material.

Rehabilitation Film Available

Filmed at the Rehabilitation Institute of Montreal (Canada), "One Step at a Time" depicts an amputee's experiences as he accustoms himself to an artificial leg and learns to use it efficiently. Consecutive steps in the process are shown: the initial fitting and use of a practice leg, the first session with the parallel bars, the learning to walk without support, the first fall, the mastery of self-confidence, rhythm, and balance. The film also provides a background to the prosthetist's craft of designing and creating a limb as well as an insight into the thoughts and emotions of the patients through the period of fitting, therapy, temporary defeats, and final victory. "One Step at a Time" will be of particular interest to professional programs in rehabilitation and therapy, and to adult education and community groups. It is 16 mm., black and white, running time 18 minutes, and may be purchased for $85 or rented for $5 from International Film Bureau, Inc., 332 S. Michigan Ave., Chicago 60604.

COMMITTEE ON CANCER CONTROL

Dr. Thomas Sellett, chairman of the Illinois State Medical Society Committee On Cancer Control, believes committees carry responsibilities to the membership and should attempt to discharge them. He is specifically concerned about the unavailability in many sections of the state of expertise in the different disciplines which are necessary for the most effective treatment of cancer patients. Having heard that a planning grant under the Heart Disease, Cancer and Stroke Law (89-239) had been awarded Illinois he decided to call a meeting of his committee and to request Dr. Wright Adams who heads the Heart, Stroke and Cancer Program for Illinois to meet with them.

The meeting was quite productive in that it disclosed the extent of confusion and lack of positive information that now exists. No one is sure to what extent the "Comprehensive Planning Law" supersedes or complements the Heart, Stroke and Cancer Law. Dr. Adams, noted for his analytical ability, although not sure of all the ramifications of the Heart, Stroke and Cancer Law, stated he would welcome grant applications. Plans for demographic studies and for medical care distribution arrangements would probably be accepted by the government. Studies in the basic sciences are not acceptable.

The report to the President by the President's Committee On Heart Disease, Cancer and Stroke published in December, 1964, was entitled "A NATIONAL PROGRAM TO CONQUER HEART DISEASE, CANCER AND STROKE." This report requested about two billion dollars to finance the program for three years. Not only diseases in the above categories were to be attacked, but any disease the Secretary of HEW thought advisable. When the bill (89-239) was passed it provided for three hundred million dollars and limited the authority to heart disease, cancer and stroke and "related" diseases. The plan was to formulate research and teaching groups, co-ordinating the facilities in a "region" and with everyone working together. The medical schools were to take a leading part in organizing these regional programs.

Somehow this program seems not to have gotten off the ground. The schools, hospitals and practicing physicians apparently have backed away from it. Throughout the Nation there are five Regional Medical Programs now in the experimental stage, but none are located in Illinois. Through this law fifty million dollars was spent in 1966 and the same in 1967. It is anticipated that in 1968 one hundred million dollars will be available.

Dr. Sellett would like to have available in every cancer patient's immediate geographic area, expert surgery, irradiation therapy, chemotherapy and isotope therapy. If any reader can think of a way in which this may be accomplished he probably could get a grant through the Heart, Stroke and Cancer Law to investigate his plan. Anyone who has such an idea may apply to Dr. Wright Adams, Executive Director of the Illinois Regional Medical Program, 122 S. Michigan Ave., Chicago, Ill.

J. Ernest Breed, M.D.

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DATE

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SPECIALTY REVIEW COURSE IN MEDICINE, Part 1, Sept. 9 & 16.
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 16
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
SURGERY OF HEAD AND NECK, One Week, September 16
SURGERY OF THE HAND, One Week, September 16
PEDIATRIC SURGERY, One Week, September 30
PROCTOSCOPY & VARICOSE VEINS, One Week, September 9
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY, Sept. 10
SURGICAL & RADIATION Rx OF GYN. MALIGNANCIES, Sept. 9
ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 16
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept. 23
DIAGNOSTIC RADIOLOGY, One Week, September 16
RADIOISOTOPES, One or Two Weeks, First Monday Each Month
BASIC ELECTROCARDIOGRAPHY, One Week, October 7
ANESTHESIA, Inhalation, Endotrachael, Regional, Request Dates

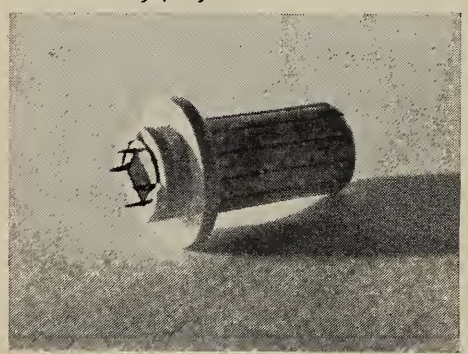
Information concerning numerous other continuation courses available upon request.

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Cook County Hospital

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Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

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MEETING MEMOS

July 20-Aug. 10—A non-credit laboratory course in basic electronics and instrumentation techniques will be given at the Polytechnic Institute of Brooklyn. This is a new course in research instrumentation.

Aug. 2—Sponsored by the Illinois State Medical Society, the Illinois High School Coaches Ass'n., and the Univ. of Illinois Athletic Association, the Fourth Annual Athletic Injury Clinic will be held at the Chicago Circle Campus of the Univ. of Illinois. This is open to all interested parties, and physicians are urged to attend and participate. They are also urged to have their school coaches attend.

Aug. 8-10—A Seminar and Workshop in techniques of Diagnostic Ultrasonics will be held in Vail, Colo. Attendance will be limited and there is a fee of $60. For information address P.O. Box 6222, Denver, Colo. 80206.

Aug. 15-17—Big Sky Medical Pow Wow, Great Falls, Mont. A high quality symposium with internationally known speakers. There will also be social activities, trips, and a football game. Ten significant medical topics will be discussed.

Aug. 19—American Medical Writers Ass'n. meeting, Drake Hotel, Chicago. Speaker: Jacqueline Seavar, free-lance writer, on "Jolly White Giants."

Hospital Utilization

(Continued from page 51)

3. Garrett, Robert Y., Jr.: 1) Come, Let Us Reason Together Address, April 1967; 2) Hospital with a Seven-day Week, Medical Economics, June 28, 1965; 3) Speech before the Institute of Nursing Service, Administration of the American Hosp. Association; 4) Seven-Day Work Week Improves Service, Modern Hospital 103: No. 5, 114, Nov. 1964; 5) Six-Day Service Makes Money and Sense, Modern Hospital, 99: No. 6, 89. Dec. 1962.
4. Gluckman, Earl C.: Operating a Hospital Seven Days a Week, Resident Physician. 9:53, Jan. 1963.
5. Haas, Ferdinand: Shifting to a Seven-Day Week, Hospitals J.A.H.A. 40:59, Mar. 1, 1966.
6. Hill, M. E.: Hospital Topics 41: 42. Sept. 1963.
7. Mulvihill, Sister M. Crescentia: Seven-Day Schedule Breaks Weekend Jam, Modern Hospital, 107:134, 1966.
8. Rauffenbart, Mary: Cooper Hospital's Seven-Day Week, American J. Nursing Vol. 63, No. XII, 1963.

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Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093 —Telephone (312) 446-8440.

FOURTH ANNUAL ATHLETIC INJURY CLINIC

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University of Illinois Athletic Association

Illinois State Medical Society

FRIDAY AUGUST 2, 1968

at the

University of Illinois Chicago Circle Campus

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Staff of 23

Open to Athletic Directors, Coaches, Physicians, Therapists, Trainers

Betamethasone 17-Valerate

(Continued from page 65)

2. Coburn, J. G.: A comparison of 0.1% betamethasone 17-valerate and 0.1% fluocinolone acetonide in the treatment of psoriasis, Brit., J. Derm. 77:590-592 (Nov.) 1965.
3. Ross, C. M.: Local steriods under polythene in the treatment of skin diseases. Double-blind trials in subtropical conditions, South African M.J. *40*:23-27 (Jan. 8) 1966.
4. Williams, D. I., et al.: Betamethasone 17-valerate: A new topical corticosteroid, Lancet *1*: 1177-1179 (May 30) 1964.
5. Zimmerman. E. H.: Betamethasone 17-valerate: A custom made topical corticosteroid, A.M.A. Arch. Derm. *95*:514-519 (May) 1967.

BLUE SHIELD REPORT FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

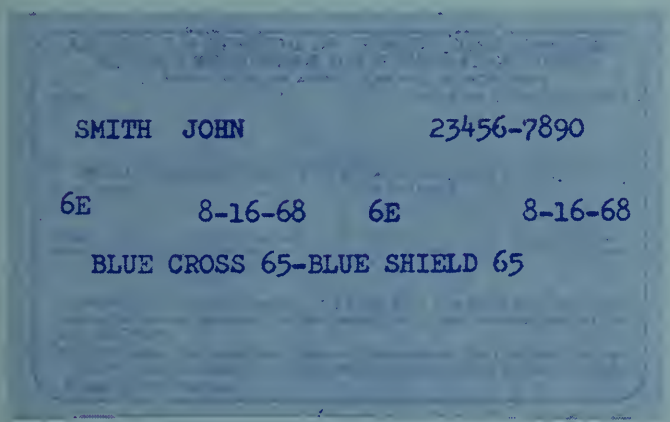
Vol. 2, No. 8 August, 1968

Blue Cross 65-Blue Shield 65 In Effect

Our new Blue Cross-Blue Shield plan for individuals over 65 became effective May 1, 1968. We have been converting members from our Series 65 Major Medical to the superior new Blue Cross-Blue Shield plan.

During the month of July we continued with our campaign to convert our Group 65 members to the new program and to enroll new members from the community who heretofore had not been protected by Blue Cross-Blue Shield.

When you or your medical assistant see your patient's Blue Cross-Blue Shield identification card with the notation "Blue Cross 65-Blue Shield 65" reproduced below,



the recommended procedure to follow is the same as you would when filing a Blue Shield claim for all other members by submitting Blue Shield's regular **Physician's Service Report** form. Please indicate the service you performed, your fee for that service, and the date you performed the service. We will pay directly to you our proportion of charges not paid by Medicare.

When you have a patient in the hospital, Blue Cross and Blue Shield provides the kind of practical protection needed to fill the gaps not covered under Medicare.

BLUE SHIELD 65

- Pays 20% of physicians' Usual and Customary fees for services in the hospital
- Blue Shield 65 also pays 20% of physicians' Usual and Customary fees for minor surgery or accident care in the outpatient department of a hospital
- Pays 20% of physicians' Usual and Customary fees for radiation therapy when a hospital outpatient or when receiving treatment in a physician's office . . . including X-ray therapy, radium therapy or radioisotope therapy for cancer
- Pays 20% of physicians' Usual and Customary fees for visits in an Extended Care Facility while receiving Medicare benefits
- In foreign countries, Blue Shield 65 will pay up to $300 in any calendar year for the same kind of physician's services this program provides in the United States

BLUE CROSS 65

- Pays in full first $40 of hospital charges per benefit period when a bed patient in the hospital
- Pays $10 per day of hospital charges during a hospital stay from the 61st through the 90th day
- Pays $20 per day from the 91st through the 820th day in each benefit period if hospital bed care is required
- Pays $5 a day from the 21st through the 100th day of care in an approved Extended Care Facility
- Outside of the U.S.A. . . . Medicare usually does not provide any benefits . . . this new Blue Cross 65 Plan pays as much as $10 a day for as long as 820 days . . . when a bed patient in the hospital

LET US HELP

For assistance in matters pertaining to Blue Shield or Medicare, contact one of our Special Representatives in our Professional Relations Department, MO 4-7100 extension 235, Blue Shield Plan of Illinois Medical Service, 425 North Michigan Avenue, Chicago 60601.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

NOTICE

To help speed Medicare payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

MEDICARE STATISTICAL HIGHLIGHTS— July 1, 1966—June 30, 1968[1]

[1]Data for June 1968—estimated

Enrollment July 1, 1968

A. Hospital Insurance (Part A)	19.7 million
B. Supplementary Medical Insurance (Part B)	18.6 million

Hospital and Extended Care Facility Admissions and Plans For Home Health Services (July 1966—June 1968)

A. Inpatient Hospital Admissions	10.6 million
B. Extended Care Facilities Admissions	640,000
C. Start of Home Health Services	485,000

Medicare Bills Paid (July 1966—June 1968)

A. Inpatient Hospital	10.6 million
B. Outpatient Hospital	4.2 million
C. Home Health Services	1.4 million
D. Extended Care Facilities	1.3 million
E. Physicians', Independent Laboratories and Other Medical Services	45.0 million

Benefits Paid (July 1966—June 1968)

A. Hospital Insurance (Part A)	$6.3 billion
B. Supplementary Medical Insurance (Part B)	$2.1 billion

Participating Providers of Services (As of June 30, 1968)

		Beds
A. Hospitals	6,900	(1,160,000)
B. Home Health Agencies	2,100	
C. Extended Care Facilities	4,700	(325,000)
D. Independent Laboratories	2,550	

Intermediaries and Carriers

A. Hospital Insurance—Blue Cross Association	1	(involving 74 plans)
Commercials	5	
Independent	4	
State Agency	1	
Other	1	
B. Medical Insurance—Blue Shield	33	
Commercials	15	
Independent	1	
State Welfare Department	1	
C. Group Practice Prepayment Plans—Direct Dealing	23	
Carrier Dealing	42	

(This is not an advertisement)

In cystitis

Rx

NegGram®

brand of

nalidixic acid

Aggressive, well-tolerated, oral therapy for most gram-negative urinary tract infections

SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

WARNING: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

PRECAUTIONS: Although prolonged treatment with NegGram has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician.

It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.

Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment, microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs.

Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added.

When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking NegGram, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to NegGram glucuronide.

ADVERSE REACTIONS: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

DOSAGE AND ADMINISTRATION: ***Adults*—Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). *Children*—According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.**

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

HOW SUPPLIED:

- **For adults**—Buff-colored, scored Caplets of **500 mg.**, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 500 and 1000.
- **For children**—Caplets of **250 mg.**, available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

Winthrop

Winthrop Laboratories New York, N.Y. 10016

Practice of Medicine in Hospitals

John C. Watson, Director of the Illinois Department of Registration and Education, has reissued an opinion of his department concerning the unlicensed practice of medicine. In light of recent disclosures of unlicensed personnel engaging in the practice of medicine in association with physicians in private practice as well as hospital practice, the *Journal* is publishing this for the benefit of members of the ISMS. The prohibitions against professional connection or association with another who is illegally practicing medicine apply to physicians in private practice as well as those in hospital or group practice.

Under the provisions of the Illinois Medical Practice Act, in addition to a duly licensed physician, there are only three classes of individuals who may lawfully practice medicine in a hospital:

1. The holder of a Temporary Certificate of Registration
2. The holder of a state hospital permit
3. An intern in an approved internship program

Temporary Certificate of Registration

A Temporary Certificate of Registration is issued to a person who is licensed to practice medicine in another state and who wishes to pursue a program of graduate or specialty training in this State in a hospital which is approved by the Department of Registration and Education for the purpose of such training. This refers to a program of specialty or residency training which is approved by the Department. The holder of a Temporary Certificate of Registration is entitled thereby to perform such acts as may be prescribed by and incidental to his program of residency training in such hospital. He is not entitled to otherwise engage in the practice of medicine in this State.

State Hospital Permit

A state hospital permit is issued in the discretion of the Department to a person who is a graduate of a medical school approved by the Department of Registration and Education and who has served a one-year internship in a hospital approved by the Department and has been appointed a physician in a hospital maintained by the State. Such state hospital permit entitles a physician to practice medicine in all its branches in hospitals or facilities maintained by the Illinois Department of Mental Health, the Illinois Department of Public Health, Illinois Department of Children and Family Services or affiliated training facilities where such practice is conducted under the authority of the Director of the Illinois Department of Mental Health, the Director of the Illinois Department of Public Health, or the Director of the Illinois Department of Children and Family Services and under supervision of a physician duly licensed under this Act to practice medicine in all its branches.

Intern

The internship is that phase of medical education and training which ordinarily follows immediately upon the completion of the four year undergraduate medical curriculum. It consists of the supervised practice of medicine in a hospital approved by the Department for such training, with continued instruction in the science and art of medicine by the hospital staff.

ECFMG Requirements

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certifi-

(Continued on page 206)

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For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

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New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

RhoGAM Biological ℞

Manufacturer: Ortho Diagnostics

Nonproprietary Name: Rho(D) Immune Globulin (Human)

Indications: Prevention of formation of active antibodies in the Rh negative mother who has delivered an Rh positive infant.

Contraindications: Rho(D) positive or D^u positive individual, Rho(D) negative patient who has received an Rho(D) positive blood transfusion, existing immunization to the Rho(D) blood factor.

Dosage: One vial, i.m., within 72 hrs. after delivery or miscarriage.

Supplied: Vials—packages of 1.

VERACILLIN Antibiotic- Penicillin ℞

Nonproprietary Name: Sodium Dicloxacillin Monohydrate

Indications: Infections due to penicillinase-producing staphylococci, streptococci, pneumococci, and also penicillin-sensitive staphylococci.

Contraindications: Hypersensitivity to penicillin.

Dosage: Adults—125 to 500 mg. q6h.
Children—12.5 to 50 mg./kg./day in divided doses, not to exceed recommended adult dosage.

Supplied: Capsules—125 and 250 mg.; bottles of 20 and 100.

DUPLICATE SINGLE PRODUCTS

PATHOCIL Antibiotic-Penicillin ℞

Manufacturer: Wyeth Laboratories, Inc.

Nonproprietary Name: Sodium Dicloxacillin Monohydrate

Indications: Infections due to penicillinase-producing staphylococci, streptococci, pneumococci, and also penicillin-sensitive staphylococci.

Contraindications: Hypersensitivity to penicillin.

Dosage: Adults—125 to 250 q.i.d.
Children—12.5 to 25 mg./kg./day in divided doses, if body wt. more than 40 kg. follow adult dosage.

Supplied: Capsules—125 and 250 mg.; bottles of 25 and 100. Powder for oral suspension—62.5 mg./5 cc.

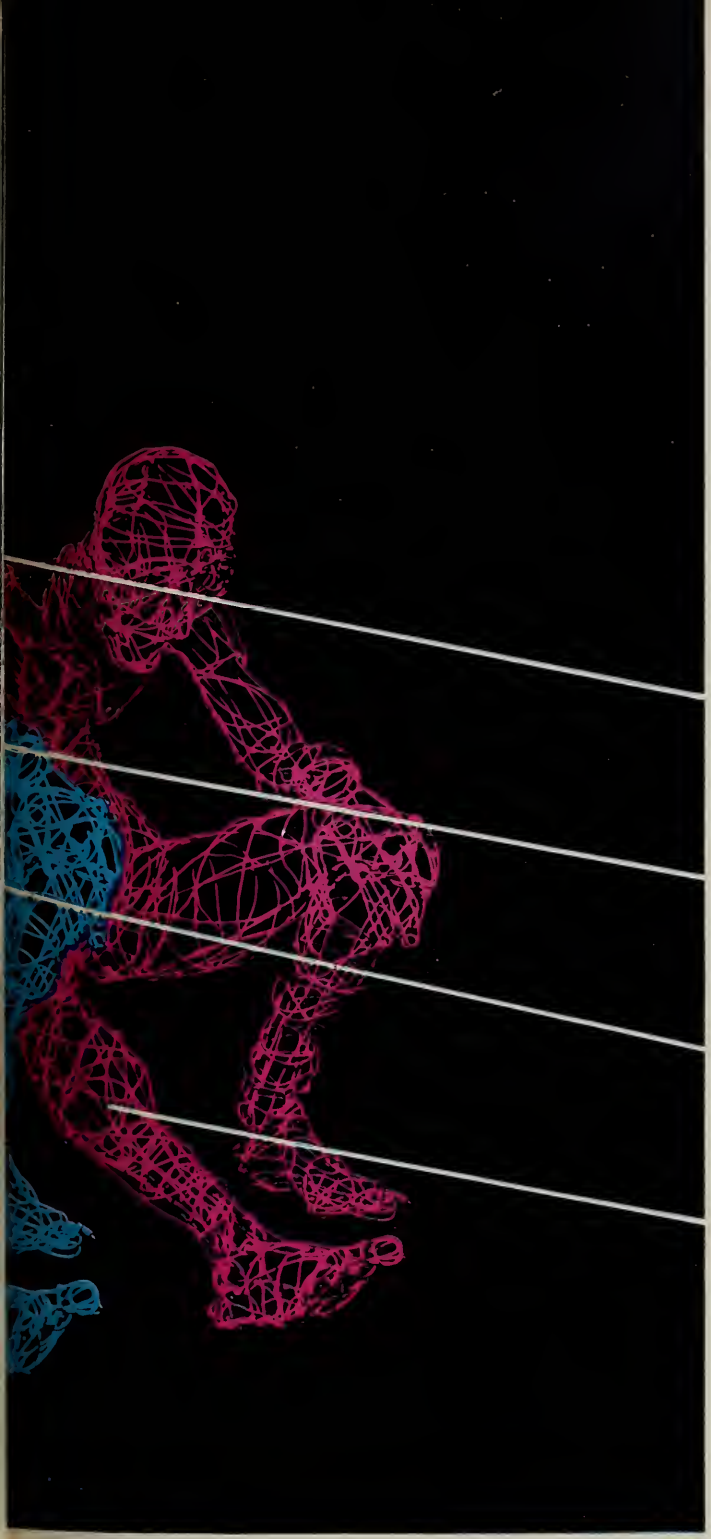
(Continued on page 136)

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Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
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For complete details, please see full prescribing information.

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Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

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Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

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SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
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Methyltestosterone	2.5 mg.	2.5 mg.
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Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
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Riboflavin	5.0 mg.	—
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New Pharmaceutical Specialties

(Continued from page 122)

COMBINATION PRODUCTS

ALDOCLOR Hypotensive ℞
Manufacturer: Merck Sharp & Dohme
Composition: Tablets:

	150	250
Methyldopa	250 mg.	250 mg.
Chlorothiazide	150 mg.	250 mg.

Indications: Sustained moderate to severe hypertension.
Contraindications: Active hepatic disease, pheochromocytoma, anuria, and mild or libile hypertension responsive to mild sedation or thiazide therapy alone.
Dosage: 1 tab. (either strength) 2 or 3 times daily, during first 48 hours, thereafter to be adjusted individually. Do not exceed 3 gm. of methyldopa or 1-1.5 gm. of chlorothiazide.
Supplied: Tablets; bottles of 100.

DIALOG with Codeine Analgesic-Narcotic ℞
Manufacturer: Ciba Pharmaceutical Co.
Composition: Tablet:

	No. 2	No. 3
Codeine phosphate	15 mg.	30 mg.
Allobarbital	15 mg.	15 mg.
Acetaminophen	300 mg.	300 mg.

Indications: Tension headache, neuralgia, more severe pain.
Contraindications: None mentioned.
Dosage: As indicated by physician.
Supplied: Tablets

NIFEREX with CALCIUM Hematinic/Vitamin Comb. o-t-c
Manufacturer: The Central Pharmacal Co.
Composition: Iron (elemental) 25 mg.
Calcium carbonate 312 mg.
Ascorbic acid (as sodium ascorbate) 125 mg.
Indications: Mineral supplement
Contraindications: Hemochromatosis or hemosiderosis.
Dosage: 2 tablets daily.
Supplied: Tablets; bottles of 100 and 1,000.

SEAFER Hematinic o-t-c
Manufacturer: S. F. Durst & Co., Inc.
Composition: Iron 40 mg.
Ascorbic acid 100 mg.
Indications: Iron deficiency anemias. Need for iron supplementation during pregnancy, onset of menses, or chronic blood loss.
Contraindications: None mentioned.
Dosage: Adults—3 or 4 tablets daily.
Children over 6 years—1 or 2 tablets daily.
under 6 years—as directed by physician.
Supplied: Tablets; bottles of 100 and 1,000.

NEW DOSAGE FORMS

DIALOG Elixir Analgesic—Non-Narcotic ℞
Manufacturer: Ciba Pharmaceutical Co.
Composition: Each 5 cc. contains:
Allobarbital 7.5 mg.
Acetaminophen 150 mg.
Indications: Relief of pain in children.
Contraindications: None mentioned.
Dosage: As indicated by physician.
Supplied: Elixir; pint bottles.

Abstracts Of Board Actions

Meeting During The Annual Convention, May 18-22, 1968

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

PRECEPTORSHIP PROGRAM IN DuPAGE COUNTY

The preceptorship program is being accepted by the physicians and students at the Chicago Medical School and has been proving to be quite successful. The resources used up to the present time have been depleted, and after the present "semester" the program will come to a halt. Five students are left and may have to cancel if money is not available. The program was a state medical society project. Perhaps the students will continue without the proposed stipend for the three months time which is involved, but DuPage County has notified the Board of Trustees and the Chicago Medical School that they are now paying the last three students, and in the future, this program will not be a county society responsibility. It has been a good program and the local society appreciates the opportunity afforded its members to work with these young people. Perhaps AMA-ERF will have some funds available if this program is considered eligible.

GUIDELINE FOR CARDIAC CARE

In again discussing the request from the nurses that their "guide lines" dealing with acute cardiac care be approved, reconsideration was asked. This was approved and the material submitted by the Illinois Nurses Association will be reproduced and mailed for consideration at a future meeting of the Board of Trustees.

HEALTH PLANNING IN COOK COUNTY

It was reported that Comprehensive Health Planning in Cook County was progressing well. Representatives of the Chicago Medical Society and five other agencies have held a series of meetings. Some decisions have been made to the effect that at the outset of the development planning period the area involved will be Cook County. Part of the study of this group will be the matter of geography with the idea of ultimately making a recommendation as to whether the area involved should be Cook County, or more extensive. It appears that this work is well up among the "leaders" throughout the country. At a meeting to be held at the Board of Health offices, a new Board of Directors will come into existance consisting of representatives from the Chicago Medical Society, Chicago Board of Health, Cook County Department of Public Health, the Metropolitan Welfare Council, Northeastern Illinois Planning Commission and the Hospital Planning Council of Metropolitan Chicago. The representative of CMS will be the Chairman of the CMS Board of Trustees.

MERGING OF EMERGENCY SERVICE

Present law makes it mandatory for every hospital to have an emergency room. In many places there are two or more hospitals close together, and one might be able to equip and man an emergency room, admit all emergency cases, and eliminate duplication of effort, supplies, manpower, etc. The Director of Public Health has appointed a committee, on which ISMS will be represented, to study possibilities for improvement in the methods of handling emergency cases.

MD ABILITY TO PRACTICE OPINION

Mr. Pfeifer, legal counsel, discussed the request that county medical societies develop a means of cooperating with the state in determining whether or not a physician is mentally or physically able to practice. Some of the counties have questions relative to procedure and relative to liability. Mr. Pfeifer was preparing an opinion which will state that the county society does have the right to make a discrete investigation, and report the findings back to this Society, and the ISMS can relay the situation to the Department of Registration and Education for further investigation and action.

VOCATIONAL REHABILITATION FUNDS DISCUSSED

The necessity to document the need for funds for vocational rehabilitation exists. After lengthy discussion it was decided that the ISMS should not appear before the legislature asking for financing without facts to back up such a request. The Board rescinded its previous action and referred the entire matter back to the Advisory Committee on Rehabilitation to meet with the Division of Vocational Rehabilitation. The Committee is to report back to the Board with facts about the need for money. The use of the advisory committee throughout the state was stressed as one of the important basic requests. There should be no departure from the use of an active medical advisory committee in any area where service is rendered.

LASER MANUAL TO BE REPRINTED

One thousand laser manuals were printed last year, and the supply has been exhausted. Requests are being received for more, and a minimum number of changes will bring the manual up to date. The booklet deals with safety precautions for the use of laser beams.

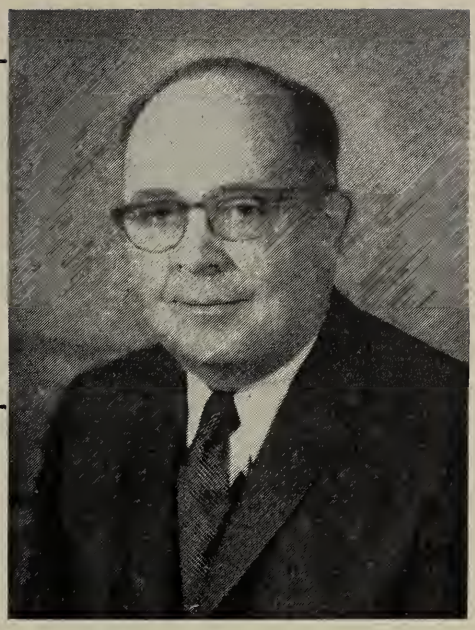
DUES STRUCTURE APPROVED

By official action, the Board approved recommending the same dues structure for 1969. The distribution of this is as follows:

AMA-ERF	$20.00
HCCI	2.00
Benevolence	5.00
Reserves	8.00
Operating Fund	70.00
	$105.00

(Abstracts continued on page 205)

The president's page



Philip G. Thomsen, M.D.

Throughout the state, starting this fall, your ISMS will go to you as never before.

We'll then be resuming the President's Tour visits inaugurated last year—and they'll be larger in substance and purpose.

The whole new format is built around this basic question: How can ISMS bring the greatest good to you. . .and to the greatest number of physicians?

To provide the greatest good, the visits will consist of an afternoon Workshop on Government Health Programs. . .and an evening presentation on problems vital to your profession and your role in society.

To serve the greatest number of physicians, most of the gatherings will be district-wide, and held in a city central to the district. The gatherings will be county-wide, however, in the very largest counties.

Our first stops will be Rockford, Peoria, Joliet, Carbondale and Rock Island/Moline, and Alton.

The afternoon workshops will cover Medicare, public aid and combinations of the two. . .townships general assistance, vocational rehabilitation, children and family services, military dependents care (CHAMPUS). Representatives of state agencies and insurance carriers will outline the procedures that participating physicians must follow. . .explain the necessary forms point by point. . .answer your questions.

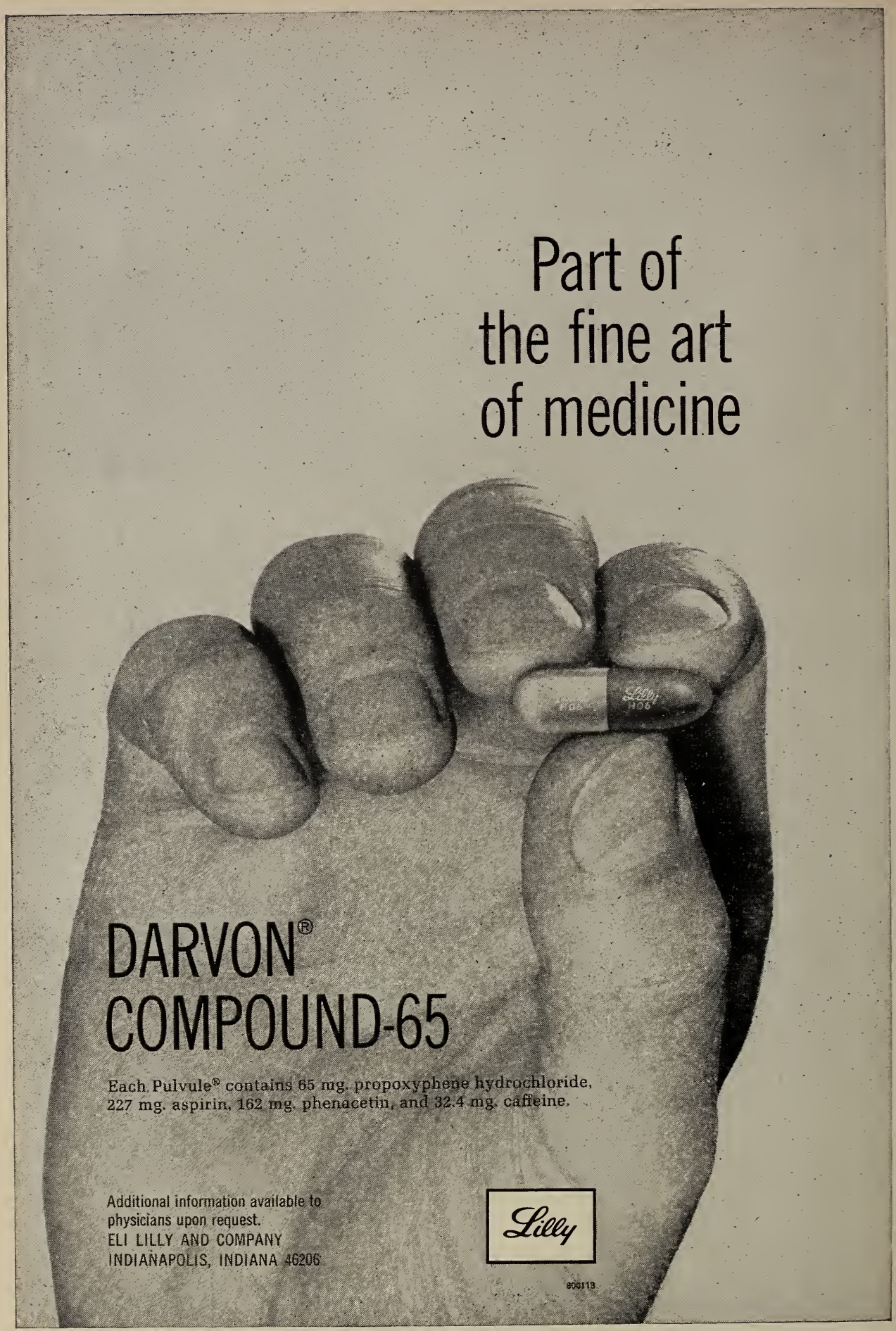
Because of confusion over the procedures and forms, Illinois doctors have been losing hundreds of thousands of dollars in rightful payments. Mindful of this, we held a "pilot" workshop last February in St. Clair County—a heavy public aid area; more than 200 physicians and medical assistants attended. Other areas across the state called for similar workshops—and we look forward to accommodating them.

In the evening of each President's Tour visit, a prominent public official—most likely your Congressman—will speak on the political, economic and social challenges that affect you and your district.

As your President, I (or in my place Dr. Edward W. Cannady, your President-Elect) will talk that evening on issues covered in the ISMS questionnaire sent you this summer. I will tell you how ISMS aims to work for the ideas that most of you favored in the questionnaire. Earlier in the day I will bring your ISMS message to a civic club and radio or TV station in the visited district.

Throughout the visit there will be give-and-take. The official family of ISMS will not only bring messages and counsel to you, but take your sentiments and spirit back home. The day's association will long outlast the day. It will be an enduring source of strength and purpose for ISMS. . . and for all of us.

Philip G. Thomsen M.D.


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IMJ
Illinois Medical Journal
volume 134, number 2 August, 1968

Myocardial Infarction During Pregnancy

By Jack J. Adler, M.D., Meyer J. Barrash, M.D., and Sidney R. Lash, M.D./Chicago

The prevalence and mortality of myocardial infarction in pre-menopausal women is less than that in men of similar age.[1,2] A more rare event is myocardial infarction during pregnancy. The exact number of such cases reported in the medical literature cannot be determined because of variation in the diagnostic criteria of myocardial infarction over the years; probably no more than 30 documented cases have been reported. Presented is a patient with a myocardial infarction substantiated by electrocardiographic and enzymatic changes occurring in the second trimester of pregnancy. Although she recovered uneventfully, she had electrocardiographic changes of ischemia during labor which promptly regressed after delivery.

Case Presentation

E. K. (180-094), a 40-year-old white woman, gravida IV, para II, six months pregnant, experienced sharp, throbbing, intrascapular pain that radiated to the precordium and left arm shortly after a meal of spaghetti and wine. She became diaphoretic and vomited without relief, and was admitted to the hospital on Oct. 4, 1965.

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Meyer J. Barrash, M.D., is Associate Attending Physician in the Department of Medicine, Michael Reese Hospital and Medical Center. He received his M.D. from the University of Chicago and did both his internship and residency at Mt. Sinai Hospital, Chicago. Dr. Barrash is also Clinical Assistant Professor of Medicine at the Chicago Medical School.
Sidney R. Lash, M.D., is from the Department of Obstetrics and Gynecology, Michael Reese Hospital and Medical Center, Chicago, where he is an Attending Physician.

Menarche at age 12 was normal, but at age 20 she was evaluated for irregular menses. X-ray studies revealed polycystic ovaries confirmed at surgery; in addition, the uterus was described as hypoplastic. A wedge resection of both ovaries was performed with the histology interpreted as simple ovarian cysts. She continued to have irregular menses with one to three-month intervals between periods. The patient was married for the first time in 1959 at age 34 years. In December, 1959 she spontaneously aborted a fetus of approximately eight weeks gestation. In 1961 and 1963 she delivered normal, full-term, female infants. No contraceptive measures were employed, and the patient states that following her abortion in 1959 she was unsuccessful in her attempts to become pregnant until 1961. However, she did have difficulty in conceiving her second and third children.

An electrocardiogram taken in 1961 was reported as within normal limits. She was known to have a low-normal blood pressure for many years, she was slightly obese, and she smoked one to three packs of cigarettes daily for more than 20 years. At the time of admission she was not taking any medication. Pertinent family history was that her father had had a myocardial infarction and congestive heart failure; two maternal uncles were known to have heart disease and diabetes.

Physical examination revealed a slightly obese, afebrile, white woman in no acute distress, with a regular pulse of 60/minute, blood pressure 90/60, and respiration 16/minute. Funduscopic examination was normal. The heart and lungs were normal. The uterus was enlarged to 2 cm. below the umbilicus. The peripheral pulses were nor-

TABLE 1
SERIAL CHANGES IN SERUM ENZYMES

ENZYME	Normal Values	Admission Date (10/4/65)	10/5	10/6	10/8	10/9	10/10
SGOT	(15-40 units)	70	100	47	28	23	15
SGPT	(15-40 units)	16	19	11	19	17	17
LDH	(200-450 units)	186	491	572	306	281	230

mal and there was no edema.

The patient was mildly anemic with a hemoglobin of 10.3 gm%. An initial leukocytosis of 12,000 WBC cleared over several days. The sedimentation rate was 14 mm. in one hour (uncorrected). Serum iron was 104 mcg% with iron binding capacity of 488 mcg%. Fasting blood glucose, blood urea nitrogen, amylase, and lipase were within normal limits. Serial changes in SGOT, SGPT, and LDH Values were as noted in Table 1. The SGOT was more than twice normal values on the day after admission, but fell rapidly to normal. The LDH values were elevated on the second and third days. Serum cholesterol was 230 mg%, with 74% esterified. Total lipids and phospholipids were within normal limits.

The first oral glucose tolerance test shown in Table 2 revealed borderline abnormalities for a pregnant woman.[3] Chest x-ray was within normal limits. Electrocardiograms taken on the first, second and third hospital days are shown in Fig. 1. The initial tracing showed alterations of acute coronary insufficiency which had regressed markedly by the next day. However, on Oct. 6 the electrocardiogram revealed evolution compatible with a recent posterior-inferior wall myocardial infarction. She did not receive anticoagulants, and was treated with bed rest and sedation. In the following four weeks the electrocardiographic changes were those of a healing posterior-inferior wall myocardial infarction. An electrocardiogram on Feb. 3, 1966 did not differ significantly from the earlier tracings. A second glucose tolerance test at 37 weeks gestation (seen in Table 2) was definitely diabetic.

On February 22, 1966 she was admitted in active labor. Analgesia consisted of meperidine and scopalamine; a pericervical and pudendal block was used for anesthesia. Her vital signs were stable and she denied chest pain during labor. Six hours after the onset of labor she delivered a 3610 gm. male infant. Electrocardiograms, seen in Fig. 2, taken during labor, immediately after delivery, and one day after delivery showed the residue of the previous posterior-inferior wall myocardial infarction with the appearance of new injury around the area of the infarction during active labor. These changes cleared immediately after delivery. An electrocardiogram taken eight weeks postpartum did not differ from one taken before delivery.

Discussion

Myocardial infarction during pregnancy and pregnancy occurring in a woman known to have had a myocardial infarct are both rare events. In 1960 Watson et al reported two cases of myocardial infarction occurring during pregnancy, and surveyed the world literature, summarizing 26 cases of myo-

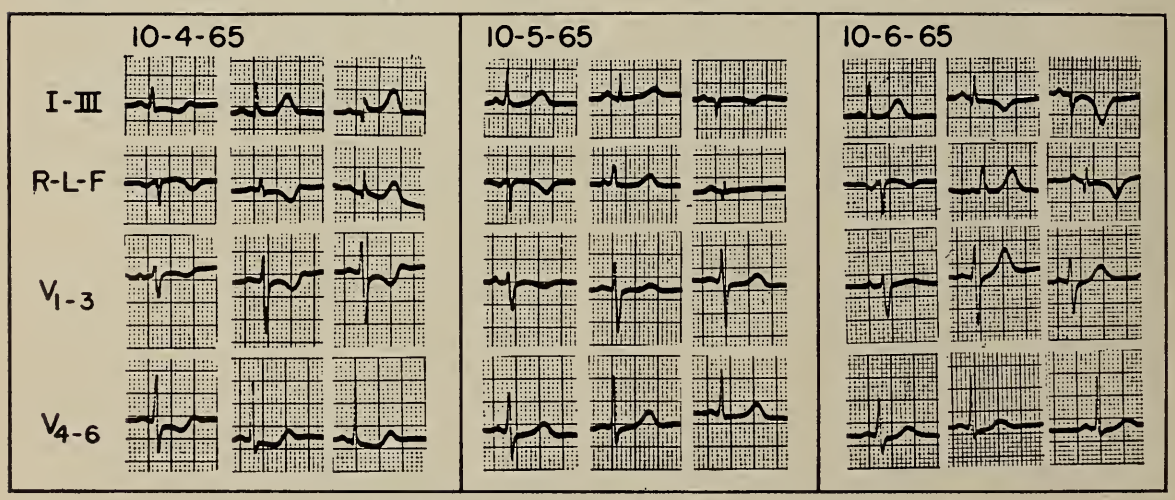


Fig. 1. Electrocardiograms during the first three days of initial admission.

cardial infarction occurring during pregnancy or the puerperium.[4] A later summary was that of Magner in which 35 cases were enumerated. He included several patients with the only diagnosis being "angina during pregnancy," and he did not include the more recent cases of Watson.[5] In an earlier paper, Mendelsohn presented four patients with the diagnosis of myocardial infarction during pregnancy.[6] However, one patient had had a myocardial infarct approximately three years before the onset of pregnancy; in two other cases the electrocardiographic findings were only suggestive and no firm evidence of myocardial infarction was presented; one could not rule out pulmonary embolism. Another case report and review was that of Lyons and Lyons.[7]

TABLE 2

ORAL GLUCOSE TOLERANCE TESTS TAKEN DURING THE COURSE OF PREGNANCY

(true glucose method)

	19 weeks gestation	37 weeks gestation
Fasting	75 mg%	98 mg%
½ hour	90 mg%	147 mg%
1 hour	149 mg%	176 mg%
2 hour	156 mg%	141 mg%
3 hour	118 mg%	141 mg%
4 hour	80 mg%	103 mg%

Since 1960 there have been occasional case reports in the literature.[8,9,10] Magner presented a case of myocardial infarction and acute pulmonary edema occurring during labor confirmed by autopsy which showed complete occlusion of the left coronary artery.[9] Another case is reported by Pfaffenschlager in a 21-year-old woman.[10] Although the occurrence of a myocardial infarction is a rare event, one cannot assume that all such cases have been reported in the medical literature. Also, some cases may be overlooked, as for example, case 2 of Watson, which was detected only by a fortuitous electrocardiogram.[4]

Another source of information indicates that myocardial infarction in women of childbearing age may not be as rare an event. On the basis of cardiovascular examinations, including electrocardiograms, of approximately 7000 people, representing a nationwide probability sample of the civilian, non-institutional population, Gordon and Garst of the Division of Health Examination Statistics, National Health Survey, predicted that 19,000 women, 24-34 years of age, and 29,000 women, 35-44 years of age, would have definite evidence of myocardial infarction. The only criterion for the diagnosis of myocardial infarction in this study was well accepted electrocardiographic changes of myocardial infarction.[1] If these prevalence figures are correct, one might anticipate that pregnancy in a woman who has had a myocardial infarction is an unusual, but not a rare event.

Another explanation of why myocardial infarction is rare in pregnant women might be that women who are prone to develop this disease are less fertile or abort, thus making the development of myocardial infarction during the pregnant state, or pregnancy after myocardial infarct less likely. Winkelstein and Rakate reported on about 60 women with atherosclerotic cardiovascular disease who showed an excess of pregnancy loss when compared with a matched group.[11] Of note was that diabetes was not responsible for this observed difference. The obstetrical history of this patient is interesting in this regard.

Several long term prospective studies have elucidated the factors that predispose to the development of coronary heart disease. The data from Framingham indicate that hyper-

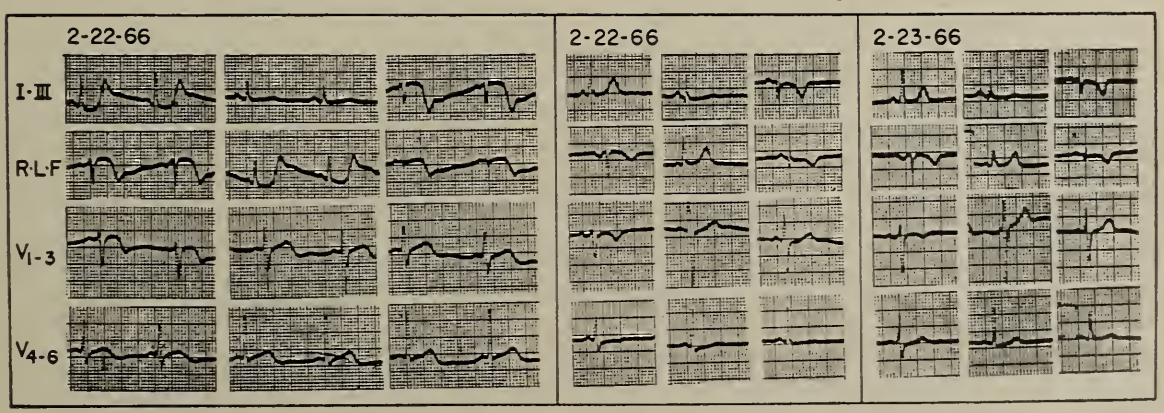


Fig. 2. Electrocardiograms during labor, immediately after delivery, and one day after delivery.

tension, elevated serum cholesterol, other lipid changes, electrocardiographic abnormalities, decreased vital capacity, excessive cigarette smoking, and perhaps other factors are associated with a higher incidence of coronary heart disease.[12] Diabetics are known to be more prone to the premature development of coronary heart disease and one study of myocardial infarction indicated that a high proportion of young men had abnormalities of carbohydrate metabolism.[13] The patient presented here would be classified as a pre-clinical or chemical diabetic who with the physiologic stresses of pregnancy developed significant alterations of carbohydrate metabolism. In the case reports studied 5-10% of women with myocardial infarction during pregnancy are clinically diabetic. The criteria for the diagnosis of diabetes vary from case to case; in addition, more elaborate testing of the patients classified as non-diabetics might have revealed subtle alterations in carbohydrate metabolism.

However, one cannot assume that these various factors have the same pathogenetic significance for a pregnant woman. For example, studies of lipid alterations indicate that normally during pregnancy the total cholesterol increases with its distribution between alpha and beta protein altered in a fashion similar to that found in men with coronary heart disease.[14] Clearly, these lipid changes in this population of pregnant women do not predispose to clinically significant coronary heart disease. It is doubtful that a long range study of coronary heart disease in pregnancy will be carried out; only one case of coronary heart disease in women 30-39 years of age was noted during eight years of study at Framingham.[12] The number of women and length of years involved in such a prospective study would be prohibitive.

Techniques of obstetrical management in the reported cases varied depending upon: 1) at what time during pregnancy the myocardial infarction occurred; 2) the parity of the patient; 3) the patient's general health and other complicating factors. From the case reports in the literature, there is no indication that a myocardial infarction, per se, is an indication for Caesarian section. As in any patient, anesthesia should be such to avoid periods of hypotension and anoxia, and enough analgesia should be employed to relieve pain and emotional distresss. Continuous caudal or epidural anesthesia may well meet both objectives by providing analgesia during labor and anesthesia for delivery. In our patient the stresses of labor produced electrocardiographic changes of acute injury although she was not hypotensive and did not complain of chest pain during labor. Anticoagulants have been used in pregnant women, usually for the more common problem of thrombophlebitis. Heparin, which does not cross the placenta, is preferable to warfarin and similar preparations.

Summary

A 40-year-old white woman suffered an acute myocardial infarction in the second trimester of her third pregnancy. Following an uneventful recoverey, she developed significant electrocardiographic changes during labor that regressed promptly post partum. The recent literature on coronary heart disease during pregnancy is briefly reviewed and techniques of obstetrical management summarized.

References

1. Gordon, T. and Garst, C. G. Coronary Heart Disease in Adults. National Center for Health Statistics, Series II, No. 10, September. 1965.
2. Cardiovascular Disease: 1960 Data on National and State Mortality Experience. U.S. Dept. Health, Education and Welfare Publication #1083, September, 1963.
3. O'Sullivan, J. B. and Mahor, C. M. Criteria for the Oral Glucose Tolerance Test in Pregnancy. Diabetes 3:278-285, May, 1964.
4. Watson, H., et al. Myocardial Infarction During Pregnancy and Puerperium. Lancet 2:523-25, September 3, 1960.
5. Magner, D. Coronary Artery Disease and Pregnancy. J. Obstet. Gynec. Brit. Comm. 69:317-23, April, 1962.
6. Mendelsohn, C. L. Coronary Artery Disease in Pregnancy, Amer. J. Obstet. Gynec. 63:381-91, February, 1962.
7. Bedford, J. R. D. Myocardial Infarction in Pregnancy. J. Obstet. Gynec. Brit. Comm. 71:459-60, June, 1964.
8. Lyon, B. H. and Lyon, R. Coronary Artery Disease in Pregnancy. Canad. Med. Ass. J. 71:267-72, September, 1954.
9. Magner, D. Coronary Occlusion in Labour. 68:128-9, February, 1961.
10. J. Obstet. Gynec. Brit. Comm.
11. Pfaffenschlager, F. Myokardinfarkt and Schwangerschaft. Wien. Klin. Wschr. 76:297-99, April, 1964.
11. Winkelstein, W., Jr. and Rekate, A. C. Age Trend of Mortality from Coronary Artery Disease in Women and Observation on the Reproductive Pattern of those Affected. Amer. Heart J. 67:481-88, April, 1964.
12. Kagan, A., et al. The Framingham Study: A Prospective Study of Coronary Heart Disease. Federation Proceedings 21:52-7, July, 1962.
13. Sievers, S., Blomquist, G. and Biorck, G. Studies of Myocardial Infarction in Malmo, 1935 to 1954. Acta. Med. Scand. 169:95-103, 1961.
14. Oliver, M. F., and Boyd, G. S. Plasma Lipid and Serum Pipoprotein Pattern During Pregnancy and Puerperium. Clinical Science 14:15-23, February, 1955.

Report of a Case with an Unusual Complication

Cystic Fibrosis Of The Pancreas

By Richard E. Dukes, M.D., and Ruth Stern, M.D./Urbana

The various clinical symptoms of cystic fibrosis have been well documented in medical literature since their first description in 1936[1]. This hereditary disease of the exocrine glands is usually manifested during the first year of life by both pulmonary and intestinal symptoms. Schwachman[2] found this symptomatology existing in 80 per cent of his cases, with 15 per cent showing predominantly respiratory symptoms. Frequently incorrect diagnoses of asthma, chronic pneumonia, bronchiectasis, or even atypical tuberculosis had been made for these patients. He reported the cases of two small infants whose presenting symptoms were hypoproteinemia, edema, and anemia. Other investigators have reported additional cases of hypoproteinemia and edema.[3,4,5,6] In a review of children with hypoproteinemia and edema, lacking signs of proteinuria or grossly faulty nutrition, pancreatic dysfunction was the most outstanding finding.[6] Our case is reported to call attention to this association.

Case Report

The patient was first seen in our clinic on April 19, 1961, when she was seven months old. She had been an apparently normal, full term infant whose birth weight was six pounds 1 ounce, and length was 19 inches. The mother had had an uneventful primiparous pregnancy, and the delivery was normal. Family history was non-informing. At the age of two months the infant had started having severe respiratory infections which responded poorly to antibiotic therapy, and ultimately a diagnosis of allergy to cow's milk had been made. As she refused the various milk substitutes, her protein intake was sharply limited.

When we first saw the child on April 19th, the physical examination revealed a fairly well developed infant of seven months. Her weight was 13 pounds 7 ounces; length, 26 inches; circumference of the head, 15¾ inches; and chest circumference 15¾ inches. The eyes, ears, nose and throat were normal, and her chest was clear to auscultation. The heart rate and rhythm were normal, and no murmurs were heard. The abdominal examination was negative. No medication was prescribed.

On April 28th she returned with acute otitis media. A myringotomy was performed, and medication with Suspension of Panalba (Tetracycline and Novobiocin) was started.

On May 5th her ear drum had healed; however, her temperature was elevated to 100.2°F. rectally. There was some puffiness about her eyes, and there were rhonchi throughout both lung fields. Laboratory tests were scheduled for May 9th. That evening, following the removal of 18 cc. of blood for the tests, the infant started having rapid, shallow respirations. Her mother was apparently unconcerned and did not bring her in until May 12th. At that time the positive findings on physical examination were: weight, 15 pounds 2½ ounces; temperature, 101°F.; bilateral serus otitis media; rales and rhonchi throughout both lung fields; ascites and pitting edema of the extremities.

The infant was hospitalized immediately, and a catheterized urine specimen obtained as the mother had been unable to collect



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a voided specimen. Urinalysis showed an acid reaction, albumin negative, sugar 2+, acetone negative, and microscopic negative. Glycosuria persisted until May 17th; subsequent urine tests were negative for glucose. Several urinalyses were done, and at no time was albumin present. Additional laboratory studies on May 9th revealed a hemoglobin of 10 grams per cent; erythrocytes, 3,500,000; leucocytes, 6,800 with 35 per cent neutrophiles; 61 per cent lymphocytes; and 4 per cent monocytes. Platelets were present in adequate numbers. Blood serum cholesterol was 305 mgm. per hundred cubic centimeters. Serum protein was 4.2 gms, with 2.5 gms. albumin, and 1.7 gms. globulin. Fasting blood sugar was 175 mgm. on May 12th. This test was repeated on May 27th, and the fasting blood sugar was 69 mgm.

The blood urea on May 15th was 10 mgm. Blood serology, both Kline and Kahn, were negative. Protein bound iodine was 9 mcg. per hundred cc. A Fibros paper test for detection of increased chloride ion in the sweat was interpreted as negative on May 5th; however, this test was repeated on May 27th at which time it was definitely positive, 3+. On May 26th, determination of the sweat chlorides using the Schales method was 208 mEq. per liter.

Treatment and Results

The patient was treated with 140 cc. of citrated whole blood on May 12th, and again with 120 cc. on May 14th. Total serum protein on May 16th was 4.9 gms. with albumin 3.2 gms., and globulin 1.7 gms. She had marked diuresis following the transfusions, and by May 23rd her weight was 11 pounds 14 ounces, a loss of three pounds four and one half ounces. The ascites and edema had cleared; however, auscultation of her chest still revealed numerous rales and rhonchi.

A culture taken from the stomach washings on May 20th revealed a pure culture of Pseudomonas aeruginosa. On May 25th she was started on Coly-mycin, (Colistimethate sodium) 6.25 mgs given intramuscularly every 12 hours, and her lung fields started to clear immediately. She was discharged from the hospital on May 31st.

At the time of her discharge, her weight was 12 pounds 9¾ ounces and her general condition was good. Occasional rales in both lung fields were the only positive physical findings. She was taking a Probana formula, and her medication consisted of Zymadrops, 0.6 cc. three times daily; Troph-Iron liquid, ½ teaspoon twice daily; Cotazym-B, one tablet with each feeding; and syrup of Aureomycin, ½ teaspoon daily. A serum protein determination on May 29th showed the total protein to be 5.5 gms., of which 3.5 gms. was albumin, 0.67 gms. alpha globulin, 0.72 gms. beta globulin, and 0.65 gms. gamma globulin.

Since her discharge from the hospital the patient has been followed as an out-patient. She has had numerous respiratory infections and has been under constant supervision because of her chronic ailment.

Comments

This case report illustrates a number of pertinent points in the diagnosis and treatment of cystic fibrosis of the pancreas in infancy. Care must be exercised in using the Fibros paper test to detect increased chloride ion in the sweat. If the test is read as negative but clinical symptoms warrant, the test should be repeated or a more definitive sweat analysis should be performed. Even when the tests are negative, caution must be exercised before assuming that cystic fibrosis does not exist. Goldman et al[7] reported a fibrocystic infant with hypoproteinemia and edema whose sweat test first showed a chloride content of 32 mEq. per liter. The repeat sweat test made after remission of the edema showed a chloride content of 119 mEq. per liter.

As is so often the case, a misdiagnosis of allergy was made for this infant. Allergy and cystic fibrosis may co-exist in many patients. This fact was well demonstrated in a series[8] when the presence of allergy was confirmed in 47 of 266 patients with fibrocystic disease. It is especially important that all infants with allergic respiratory symptoms also be checked carefully for cystic fibrosis.

The dietary restrictions of this patient, and her failure to take the milk substitutes, along with her repeated infections, undoubtedly contributed to her hypoproteinemia. The type of protein consumed might also be a factor as one fibrocystic infant with hypoproteinemia was found to have excreted as much as 80 per cent of the ingested nitrogen as fecal nitrogen while receiving a soybean formula.[4] The removal of 18 cc. of blood from an infant already show-

ing some evidence of edema was the final factor in precipitating the anasarca.

Marie et al[3] reported hyperglycemia in one of their cases. In our patient the glycosuria and hyperglycemia cleared spontaneously, but not before causing considerable confusion. We do not have an adequate explanation for the cause of the glycosuria and hyperglycemia.

The use of gastric lavage to obtain stomach washings for culture should not be overlooked. The finding of a pure culture of pseudomonas in the gastric washings of this infant while receiving therapeutic doses of tetracycline and novobiocin resulted in a change of therapy. Coly-mycin (colistimethate sodium), given intramuscularly twice daily, had an immediate beneficial effect, and within six days her lungs were clear to auscultation. This occurrence further points out the importance of bacterial cultures in treating this condition.

Summary

A case of cystic fibrosis of the pancreas with hypoproteinemia and edema is presented. The importance of differentiating cystic fibrosis from allergy is emphasized as well as the help that may be derived from bacterial cultures. The practice of using stomach washings to obtain material for culture from infants should not be overlooked.

References

1. Fanconi, G.; Uehlinger, E.; and Knauer, C.: Das Coeliakiesyndrom bei Angebroener Zystischer Pankreasfibromatose and Bronchiektasien, Wien. med. Wschr. 86:753-756 (July 4) 1936.
2. Schwachman, Harry: Therapy of Cystic Fibrosis of the Pancreas, Pediatrics 25:155-163 (Jan.) 1960.
3. Marie, J.; Salet, J.; Debris, P.; Hebert, S.; Corbin, J. L.; and Bezri, A.: Les Formes Oedemateuses avec Hypoproteinimie et Anemie de la Fibrose Kystique du Pancreas, Semaine des Hopitaux de Paris 35:2140-2146. June-July 1959.
4. Fleisher, Daniel S.; DiGeorge, Angelo M.; Auerbach, Victor H.; Huang, Nancy N.; and Barness, Lewis A.: Protein Metabolism in Cystic Fibrosis of the Pancreas, Am. J. Dis. Child. 100:590. (Oct.) 1960.
5. Henderson, W.: Fibrocystic Disease of the Pancreas with Hypoproteinaemic Oedema in Early Infancy. Proc. Roy. Soc. Med. 48:1107. (Dec.) 1955.
6. Bille, B. S. V. and Vahlquist, B.: Idiopathic Hypoproteinaemia Versus Hypoproteinaemia Due to Pancreatic Dysfunction. Acta Paediat. 44:435-443. 1955.
7. Goldman, A. S.; Travis, L. B.; Dodge, W. F.; and Daeschner, C. W., Jr.: Correspondence: Falsely Negative Sweat Tests in Children with Cystic Fibrosis Complicated by Hypoproteinemic Edema, J. Pediat. 59:301. (Aug.) 1961.
8. Kulckycki, L. L.; Mueller, H.; and Shwachman, H.: Respiratory Allergy in Patients with Cystic Fibrosis, J. A. M. A. 175:358-364. (Feb. 4) 1961.

Northwestern Neurologist Pinpoints Four Critical Periods in the Life of the Epileptic

A Northwestern University neurophysiologist has pinpointed the four critical periods in the life of the epileptic.

Dr. John Hughes, a specialist in electroencephalographic (EEG) research, located the danger periods in a study of brainwave patterns of 1,355 epileptics.

The research was singled out by Dr. James A. Shannon, director of the National Institutes of Health in Washington, in a recent report to the U.S. Surgeon General. The Hughes work was performed under an NIH grant.

Dr. Hughes found that epileptic brain wave patterns occur most frequently around the ages of six, 14, 35, and 60. Epileptic seizures could be expected to occur more often in these age periods than at other intervals of life, he reported.

His findings suggest that the four periods are critical because of external and internal stresses facing epileptics during these intervals.

At six, he theorizes, the child has his first confrontation with formal elementary school education. At 14, he enters the hormonal and behavioral turmoil of adolescence.

Around 35, he can anticipate a peak in his struggle to succeed professionally or a period of soul-searching about his career —under the theory that if one hasn't made his mark by then, he never will.

And at 60, he faces the prospect of retirement, with all of its emotional by-products and feelings of uselessness in addition to organic changes during the aging process.

The full Hughes study was recently published in the journal, "Epilepsia," the official scientific journal of the International League Against Epilepsy.

Report of a Panel from the Illinois Psychiatric Society

The Treatment of Schizophrenia

Reported by Hyman L. Muslin, M.D./Chicago

On 18 October, 1967, the Illinois Psychiatric Society had as its first scientific presentation of the year a panel meeting to discuss the treatment of schizophrenia. This meeting chaired by Dr. Nathaniel Apter featured Dr. Peter Giovacchini and Dr. Daniel X. Freedman who presented their particular overviews of the treatment of schizophrenia.

Dr. Freedman presented his remarks first and emphasized that "Currently, treatment for those disorders called schizophrenia cannot be directly coupled with questions about etiology. There are several schizophrenias probably determined by the relative weighting of genetic, neonatal, experiential, psychosocial, as well as biochemical factors. Really conclusive evidence for the specific role of any factor is lacking. The only credibly solid advance has been in the field of the potent tranquilizers which freqently aid but do not insure cure . . ." Dr. Freedman then pointed out that, ". . . the patient's needs and his assets and liabilities for adjustment are practically assessed, and from the range of available treatment strategies, selections are made." Continuing along this line Dr. Freedman pointed out that, "The objective evidence (Davis, J.M.: Arch. Gen. Psychiat., *13*:552, 1965) clearly indicates that appropriate phenothiazine treatment is a definite advantage in most schizophrenias."

Dr. Freedman's thoughts about the relative merit of psychotherapy were continued in the following remarks, "Classical psychoanalysis can refer to theory or to Freud's clinical method. He did not recommend the method for the major psychoses since the procedure requires considerable personality strength and sustained ability to make distinctions in reality. Selecting elements from the classical approach, some skilled therapists of schizophrenic patients have applied —not imitated—the techniques and principles of psychoanalysis. Appropriate talking therapies can assist some patients (even the schizophrenic) to improve, yet occasionally patients may decompenstate just as with other therapies. There is no evidence that suicide is more closely associated with one rather than another therapy; rather suicide is associated with a variety of stresses and disorders."

Dr. Freedman summarized his comments about psychoanalytic treatment in the following manner: "Any systematic use of psychoanalytically informed therapy is in my opinion useful on occasion and any strictly psychoanalytic procedure is investigational."

Schizophrenic Patients Can Be Treated

Dr. Giovacchini's remarks emphasized to the contrary that, "More analysts today believe that many schizophrenic patients previously thought inaccessible to psychoanalysis can be so treated. Schizophrenic patients may seek and benefit from a therapeutic relationship that does not include advice to relatives, elimination of tension states and symptoms before their adaptive significance can be understood (as sometimes happens with tranquilizers), or any activity designed to manage their lives."

Dr. Giovacchini felt that treatment approaches in schizophrenia in many instances is eclectic unnecessarily and the eclectic approach bypasses coming to grips with the fundamental causes, namely, the intrapsychic malfunctioning. In his words, "It has often been stated that not too much is known about its intrapsychic aspects. This raises several questions:

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1) The intriguing question as to the type of data required to gain more information.
2) The relevance of such knowledge to therapeutic approaches.
3) What constitutes improvement beyond conformity and superficial social adjustment.

He went on to state, "The first two questions are interrelated and can be partially answered together. Intrapsychic aspects refers to psychic processes determined by archaic ego levels that are reproduced in the transference. In psychoanalysis the transference recapitulates infantile traumas and disruptive object (interpersonal) relationships that determine later psychopathology. To learn about these etiological factors one has to offer the patient an analytic setting. Investigative approaches and therapy are congruent. The transference relationship is the most relevant tool we have to learn about intrapsychic processes and character structure from a microscopic viewpoint."

"Improvement can thus be viewed in terms of structural changes rather than mere phenomenology. Again this assessment requires the transference setting. One can look at changes from a gross viewpoint but as in medicine the disappearance of symptoms does not necessarily indicate that the patient is fundamentally better. The transference offers us the opportunity of observing changes that are not phenomenologically apparent. It is analogous to a microscope. One can infer considerably about micro-organisms but to see them one requires a special instrument."

As a brief example of some aspects of clinical material that emerges in a psychoanalytic setting Dr. Giovacchini gave the following, "A videotaped interview of a withdrawn schizophrenic supplies the data to illustrate certain aspects of the analytic setting which I believe make it possible to treat more such patients than is initially believed. If the patient allows the therapist not to intrude in his psychopathological frame of reference, then it becomes possible to establish a therapeutic relationship. Intrusion means becoming involved with the patient's content rather than focusing upon its intrapsychic sources and adaptive value. Having told the patient that he could withdraw to reveal himself as he chooses caused him to become agitated and unable to maintain apathy. He became aware of some autonomy which had been submerged by a defensive, super-structure. This created conflict (ambivalence about symbiotic fusion) but also a realization that the psychopathological world was, at the moment, his creation. By not entering his world the intrapsychic sources of his difficulties were highlighted and he became therapeutically accessible."

Treatment Plans

The discussion from the floor and from the principal speakers (including Dr. Apter) made it clear that in discussing the treatment of schizophrenia the focus, i.e., the material for discussion, has to be sharply defined. Dr. Giovacchini's frame of reference, the focus on the intrapsychic aspects of mental functioning, including the functioning of the schizophrenic as valid data for analysis is not Dr. Freedman's focus per se. Dr. Freedman's view represents an attempt to assess the multitude of variables serving as causal factors and serving to influence the course of treatment. Treatment for Dr. Freedman implies reduction in symptoms of disordered interpersonal relationships and ability to function, i.e., a treatment plan may include a variety of treatments perhaps including intensive psychotherapeutic work.

Summary

Dr. Apter and Dr. Daniels summarized the results of the meeting appropriately by reminding the audience that achieving a synthesis of differing points of view is sometimes unattainable especially in complex areas of diagnosis and treatment. From another point of view, Drs. Giovacchini and Freedman's research approaches and research goals in this area more clearly define their interests; Dr. Giovacchini's research leads him to defining the nature of the intrapsychic experiences and processes in the schizophrenic. Dr. Freedman's research leads him to defining and describing neurophysiologic, biochemical, social and intrapsychic mechanisms some necessary, some sufficient in the production and maintenance of the schizophrenic disorders.



THE DOCTOR'S LIBRARY

CANCER OF THE BREAST. By John S. Spratt, Jr., and William L. Donegan. Volume V in the series, "Major Problems in Clinical Surgery" edited by J. Englebert Dunphy. W. B. Saunders Co., Philadelphia, 1967.

This volume is No. V in a series of monographs, "Major Problems in Clinical Surgery." The high calibre of presentation established by the previous four volumes has been maintained in this latest publication under the supervision of the consulting editor, Dr. J. Englebert Dunphy.

The authors have reviewed the subject of mammary cancer and have based their presentation on information from the literature and clinical material from the Ellis Fischel State Cancer Hospital. They have gathered together an impressive amount of information and presented it in a concise and understandable manner. The book is well organized and well illustrated.

The first chapter which deals with the anatomy of the breast includes a lucid description of the lymphatic and vascular supply of the breast. The next chapter is concerned with epidemiology of mammary cancer. The presentation concerned with diagnosis is particularly well illustrated. The diagnostic value of mammography, thermography, and cytology are thoughtfully evaluated.

A section which describes the pathology of mammary carcinoma was written by Doctor Carlos Perez-Mesa, Chief Pathologist of the Ellis Fischel Hospital, and correlates the prognosis with various types of breast cancer.

The surgical techniques which are described include not only mastectomy, but oophorectomy, and adrenalectomy.

Staging and end results are given adequate consideration. There are a few minor discrepancies in this portion of the book. The author states that there has not been a sufficient lapse of time to allow adequate evaluation of the so-called "modified" radical mastectomy, and yet later states that "it appears likely that the modified procedure may play an increasing role in the treatment of early mammary cancer". This is in contrast to most of the highly objective discussion elsewhere in the book.

The role of radiation therapy receives attention. Mammary cancer and pregnancy, cancer of the second breast, recurrent disease, sarcoma of the breast are discussed.

Endocrine ablation, hormone therapy, and chemotherapy receive appropriate attention, and a plan of management for patients with disseminated mammary cancer is presented

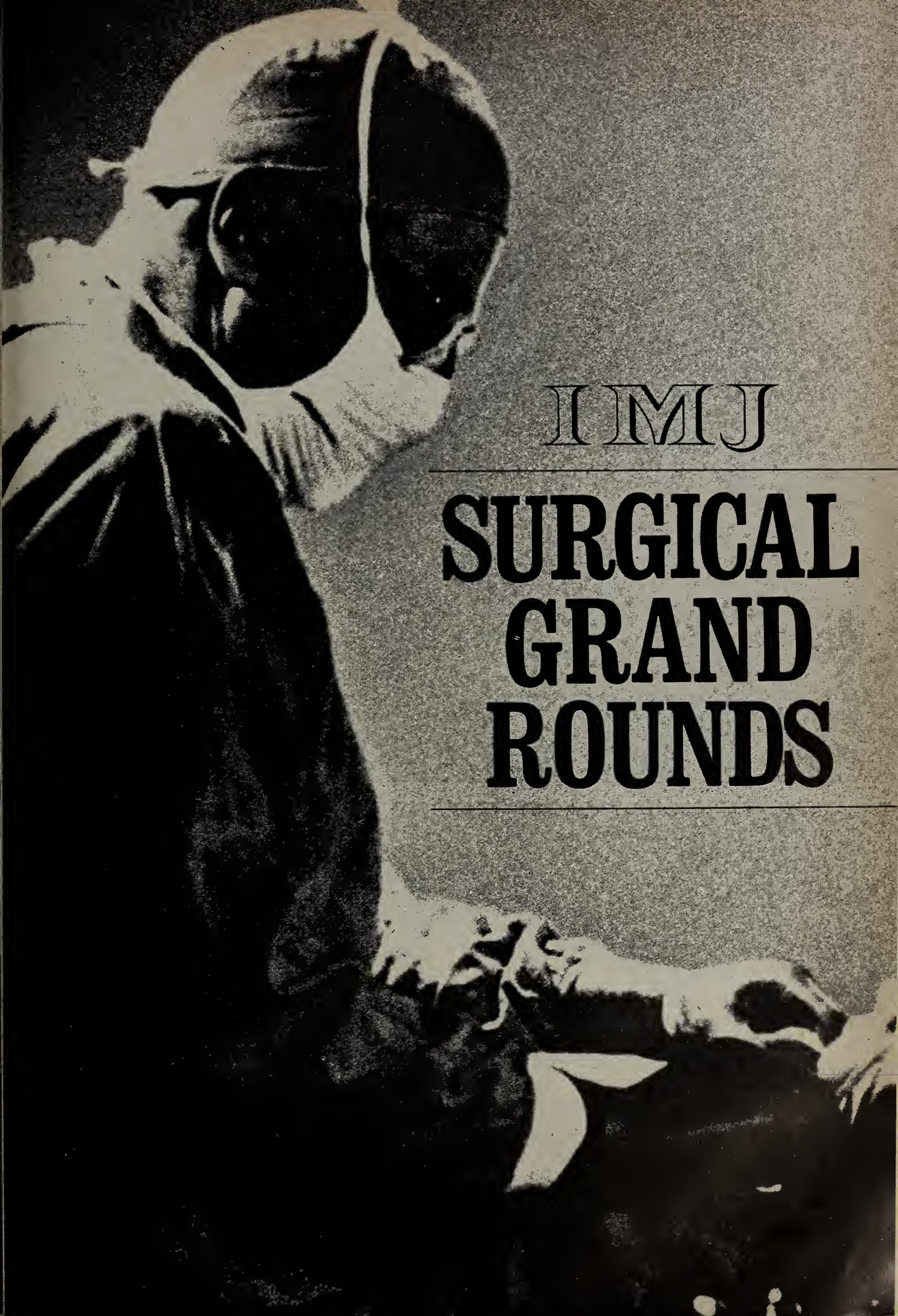
The final chapter is a useful presentation of statistical methods in cancer research as applied to breast cancer and should be of value to anyone who is assembling data in this or related fields.

Each chapter is followed by a carefully selected bibliography.

The volume is recommended to those who are interested in breast cancer and should be of particular value to physicians in residency training.

John M. Beal, M.D.

A small brochure, entitled "What's New on Smoking in Films" has been issued by the Department of HEW, Public Health Service, 4040 N. Fairfax Dr., Arlington, Va. 22203. Listed are films and filmstrips of the member agencies of the National Interagency Council on Smoking and Health. The subjects cover a wide range of interests and are directed to many audiences, including both young people and adults, smokers and non-smokers. "What's New on Smoking in Print," a companion leaflet, is also available.



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SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M., alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on November 18, 1967.

Neurogenic Claudication

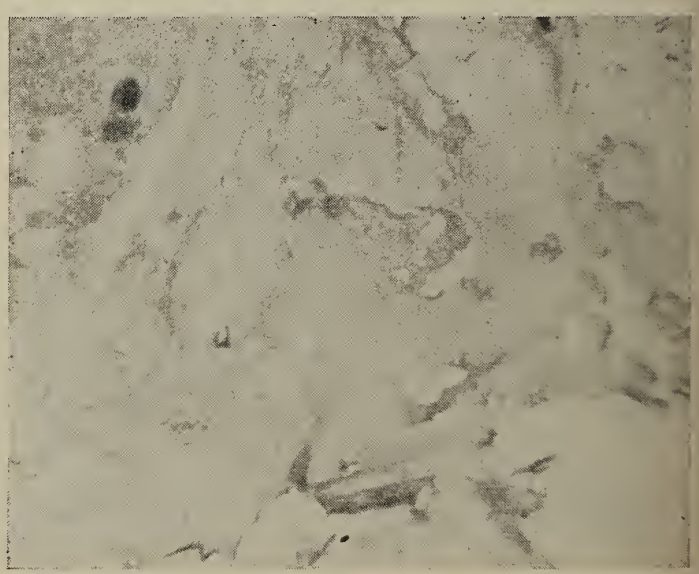
Case Presentation:

Dr. Charles McHugh: The patient, a 57 year old salesman, entered Passavant Hospital with a chief complaint of pain in his left leg. Approximately three years before his admission he had the onset of back pain, which radiated to his left hip, to the left anterior lateral thigh and later into the calf of the left leg. At first he noted this pain only when playing golf so that he could play only five holes. Over the following three years the pain increased in severity so that he was able to walk only about 50 feet when admitted. He described the pain as sharp and cramping pain in the calf and relieved by rest. In addition to the pain associated with exertion, he also noticed a constant discomfort in the calf, and at night he was frequently awakened by a pain in the calf which was relieved by flexing his legs repeatedly. He has been impotent for a three year period.

Examination at the time of admission revealed blood pressure 160/90 and pulse 90. The fundi demonstrated mild atherosclerotic changes of the retinal vessels. Chest and abdomen were normal. In the extremities the only significant findings were limited to the left lower extremity where femoral, popliteal, dorsalis pedis, and posterior tibial pulses were present but diminished. Neither trophic changes nor atrophy of the musculature of the left leg were present. Diminished dorsal flexion of the left foot was detected. The oscillometry was diminished in the left calf. Neurological examination demonstrated a slight loss of vibratory sense in the left lower extremity and slightly diminished competence in straight leg raising on the left with discomfort in the low back with forced dorsal flexion. Laboratory examination revealed a diabetic glucose tolerance test. An electrocardiogram was unremarkable. Electromyography demonstrated a general slowing of nerve conduction, particularly in the lower extremities. A number of x-ray studies were obtained.

Dr. Hirsch Handmaker: The lumbar spine radiograms show bilateral facet changes, with narrowing and minimal reactive sclerosis. The left hip demonstrates joint space narrowing and considerable proliferative change and an appearance suggesting old slipped capital femoral epiphysis. A right retrograde femoral injection of contrast media was performed, and normal left iliac superficial and deep femoral arteries were outlined by reflux into the aorta and crossover. The entire right iliac deep and superficial femoral arteries and their branches were normal. Neither side showed intimal irregularities. A lumbar myelogram was performed next and showed asymmetry at the L4 level on the right with a filling defect strongly suggestive of an extradural lesion, most likely herniation of the L4 nucleus pulposus (Fig. 1). Additionally there is questionable extrinsic pressure at L5 on the right.

Fig. 1: View obtained when lumbar myelogram was performed is compatible with herniation of L4 nucleus pulposus.



Dr. Nicholas Wetzel: A hemilaminectomy was planned. The operation was begun with the patient in the customary prone position. The patient had a rather large abdomen. After the patient had been anesthetized, the anesthesiologist reported considerable irregularity of pulse. The patient was removed from the operating table. Pulse and blood pressure were found to be normal so that he was repositioned and operated upon in a lateral position. This is a very reasonable way to operate on people, particularly obese people, and is probably harder on the surgeon than it is on the patient. Patients breathe better when they are lying on the side rather than prone, particularly if they have a large abdomen. The lateral position relieves pressure on the abdomen which may cause venous congestion in the extradural veins and create technical difficulty. We inspected the L4-5 interspace and found a bulging, rather lumpy anulus, opened this and removed a moderate amount of soft, obviously degenerating disc material. His postoperative course was quite uneventful and he has been relieved of his pain on walking. He has been able to return to his work.

The causes of back pain and sciatica are varied. There are even recent reports from Philadelphia of some patients with herniated nuclei in the cervical region associated with fairly typical sciatica. They were relieved of their sciatica by an operation on their neck. The case which has been presented illustrates the need to distinguish vascular disease from herniated nucleus pulposus. An occasional patient with vascular disease has been subjected to operation for herniated disc.

Sciatica has been attributed to many causes. At one time a group of orthopedic surgeons considered sciatica to be caused by a disturbance of the lumbosacral joint. A variety of operations were proposed. Over 30 years ago Doctors Mixter and Barr of Boston described the symptom complex associated with herniated nucleus pulposus. Unfortunately many consider all back pain and sciatica as being due to the herniated nucleus. This is certainly not true because anything that impinges on the appropriate nerve root can cause sciatic radiation of pain. A serious problem is found in patients with retroperitoneal malignancies. An accurate diagnosis may be difficult. We managed to collect a series in which presumably competent surgeons, including ourselves, had operated upon people for herniated nucleus and then subsequently discovered that they had a retroperitoneal malignancy. This patient today illustrated that herniated nucleus can mimic vascular disease.

I find that intermittent claudication is a misnomer. Claudication comes from the Latin meaning to limp. These people don't limp so much as they just stop walking.

Dr. John Beal: Dr. Conn was involved in the evaluation of the patient and performed the angiograms in association with the radiologist.

Dr. Julius Conn: This patient's physical findings were responsible for the initial impression that he had vascular disease. In addition he had typical rest pain. He would awaken at night with pain and hang his feet over the side of the bed much as people will with vascular insufficiency. The arteriogram on this patient illustrates certain diagnostic points. It seemed inadvisable to perform a translumbar aortogram because of the vagaries of his back pain and hip pain. Therefore, the apparently normal femoral artery was cannulated and a retrograde injection was done which visualized the opposite side. This demonstrated a normal aorto-iliac segment and good distal vessels.

The diagnosis of neurogenic claudication is a term coined by an English neurosurgeon. Three case reports now appear in the British literature. This symptom complex has been found with herniated discs and with arachnoiditis. The elimination of occlusive peripheral arterial disease by arteriogram is essential. The presence of pulse at rest is not enough. This patient was exercised and his pulses did not disappear. Many patients who complain of claudication about the hip will have normal pulses and yet have iliac obstruction. If they exercise their peripheral pulse will disappear. The English have reported that exercise to the point of pain will accentuate the neurologic findings.

In addition to the causes of sciatica mentioned by Dr. Wetzel, hypogastric aneurysm may be added, which may cause typical sciatic distribution pain when the aneurysm impinges on the sciatic nerve.

Dr. John Beal: Dr. Conn, are there any clinical features of the pain in a patient

with claudication that might arouse suspicion of neurogenic rather than vascular origin?

Dr. Julius Conn: Usually pain of neurogenic origin will be located in anteriolateral portion of the thigh, and progresses from a proximal to a distal location. Vascular pain usually arises first in the calf and progresses proximally. Vascular pain is commonly described as an aching pain rather than the burning pain associated with nerve disease. The most significant physical finding in a patient with neurogenic pain is the presence of normal iliac femoral popliteal pulses bilaterally, at rest and after exercise.

Dr. Joseph Sherrick: The histopathological findings in degeneration of the nucleus pulposus are not well described in textbooks. Normally the intervertebral disc is composed of a peculiar type of fibrocartilage. In Figure 2 fragmentation, fibrillar degeneration and condensation at the edges of the fragment are demonstrated. These are the changes associated with herniation.



Fig. 2: Microscope examination of intervertebral disc demonstrates degeneration in fibrocartilage of the disc.

Inpatient Unit for Retarded Children Opens in Springfield

The first inpatient habit-training unit for mentally retarded children in the Illinois mental health zone system was opened recently at the Andrew McFarland Zone Center in Springfield.

The new unit, Stephen A. Douglas Hall, is the fourth inpatient unit to be opened at the center and will service the 18 counties of Zone V in west-central Illinois.

"The program for these children will provide intensive training in meeting such personal needs as dressing, toileting, bathing and feeding," Dr. Charles E. Beck, Zone V director, said. "We expect the training period will range from three to six months for most children involved in the program."

The training program will be open to mentally retarded children, ages three through 15, from Adams, Brown, Hancock, Pike, Schuyler, Calhoun, Cass, Greene, Jersey, Morgan, Scott, Logan, Mason, Menard, Sangamon, Christian, Macoupin and Montgomery Counties.

"One of the major problems confronting families of mentally retarded children is management, both in the home and the community," Beck said. "If a retarded child can be taught ways to meet these vital, everyday needs, his chances of becoming a lifetime resident of a state institution are reduced greatly and, hopefully, eliminated."

Beck said one of the most important aspects of the new program will be the mother's direct participation in her child's training program. Whenever possible, the mother or person directly responsible for the child's care at home will be encouraged to take part in the program on a daily basis, he explained.

"By learning the specific techniques the training team used to develop these habits, the mother will be able to follow through successfully when the child returns home," the director said.

If commuting problems prevent a mother from regular participation, arrangements will be made so she can take part in the training program, Beck said.

In addition to the new unit, McFarland also operates three other inpatient units offering diagnostic and short-term treatment to children through age 12 years; adolescents, ages 13 through 17; and adults from Macoupin, Montgomery and Christian Counties.

Illinois Medicine - A Century Ago

By W. D. Snively, Jr., M.D., F.A.C.P. and Barbara Becker, B.A./Evansville, Ind.

To envision what it was like to practice medicine in Illinois a century ago, let us focus on the decade between 1860 and 1870; that period in which the United States suffered a hideous Civil War which threatened the very future of the nation, Pasteur discovered anaërobic bacteria, Lister introduced antiseptic surgery, Hoffmann discovered formaldehyde, and Liebreich demonstrated the hypnotic effects of chloral hydrate.

As the bells tolled in the first year of that eventful decade, most Illinois doctors could easily remember the rough pioneer times. Only 15 years before, Dr. Patrick Gregg, respected physician of Rock Island, had attended Col. George Davenport, revered Indian trader and founder of Davenport, Iowa after "Banditti of the Prairie", who were later to hang for their crime, attacked the good colonel in his island home. After shooting him through the thigh, beating him and pouring water over him they took all the valuables in the house and fled. We can be sure that Dr. Gregg put a tourniquet on the colonel's thigh, gave him stimulants and did all then possible. To survive, the patient needed a skilled operating team in a modern hospital. Neither was available nor would they be for many years to come. Colonel Davenport—and thousands like him—could not wait.

Today, most of us feel that we live in hazardous times. The toll of death and injuries from traffic accidents appalls us. The world finds itself in a state of turmoil abounding in wars and threats of wars. The menace of bombs riding intercontinental missiles hangs over us. Many believe that the stresses of modern living contribute to such ailments as peptic ulcer, neurosis, and coronary artery disease.

Not surprisingly then, we sometimes gaze nostalgically at the 19th Century. We picture heartwarming Currier and Ives scenes: "Home to Thanksgiving," "A Home in the Country," "Skating in Central Park," scenes of hunting in the virgin forests, fishing in roiling streams, pursuing buffalo on broad prairies. Continuing our contemplation of the past, wintertime vignette of drifting snow, sleigh bells and bountifully festive tables flow before our mind's eye. But, a forbidding spector stands in the



background of each cheery scene, its grim presence more a threat to life and limb than all today's hazards to health added together. That spector was disease, but not disease as we know it today.

THE AILMENTS

Disease of the 1860s revealed its ugly face in many ailments, most of them striking down infants, children and young people. An appalling percentage of infants died, chiefly because of primitive sanitation and fulminating infections. The grisly hand of disease might strike anyone at any time with ague, or abscesses, buboes or consumption, Asiatic cholera, erysipelas, malaria, milk sickness, pneumonia, scarlet fever, smallpox, scrofula, scurvy, and the strangling diptheria. Surgery, in truth a last resort, was primitive, and accompanied by an awesome mortality rate.

Inevitably, our 19th Century forebearer's lives were deeply involved with disease. A letter written to Mrs. Margaret T. Lamphier, daughter of John Hart Crenshaw, of Shawneetown, by her sister-in-law, Ade-

line Crenshaw, gives an intimate view of its terror. She wrote:

"We have been very much troubled with sickness this summer; Margaret Ann and Mary Lawler are both sick but I do not think dangerously. Little Sis is very ill; she has been so three days and without a great change. Soon I fear, we shall lose her."

"I began this letter yesterday, but Sis got so much worse I had to quit and she is but little better today. She had a very hard fit and about 50 spasms. She has no fever today, but is perfectly exhausted for want to sleep, as she is so troubled with worms she gets choked every few minutes . . . I am very uneasy about her. If she does not get a great deal better soon, she can't live long."

Asiatic cholera frequently visited Illinois. This diarrheal disease repeatedly swept over the world in great pandemics, often killing its victims in less than one day. Four centuries before Christ, someone described a patient with cholera thus:

"The lips blue, the face haggard, the eyes hollow, the stomach sunk in, the limbs contracted and crumpled as if by fire, those are the signs of the great illness which, invoked by a malediction of the priests, comes down to slay the braves. . ."

Doctors of the sixties could remember all too well the terrible cholera epidemic of 1854, and they knew that the scourge could return at any time. Cholera plagued the entire Midwest until about 1875 when improved sanitation dispelled the filth that caused the epidemics.

Milk Sickness

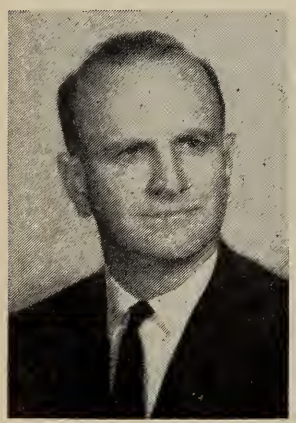
Milk sickness remained a dreaded plague in rural areas during the decade of the sixties although its incidence had decreased from the early pioneer days when it was probably a leading cause of death. Older doctors remembered how it killed one of four in some pioneer communities; how Abraham Lincoln's mother, great aunt, great uncle and two neighbors died from it in 1818 in one six-week period. Milk sickness followed the drinking of milk from cows which had eaten white snakeroot, a lovely, inoffensive-looking flowering plant with a faint aroma of lilacs. Even today, white snakeroot abounds in the Illinois countryside; take a leisure drive in the autumn and you will see it in shady zones along the roadsides.

Malaria, too, remained a feared disease during the sixties and later. Dr. C. D. Johnson, who practiced in Champaign County, was to write in his memoirs:

"Towards the close of the summer in 1872 came the last general, extensive endemic of malaria fever experienced in Central Illinois. This endemic lasted from the last days of July to the coming of a killing frost and within the bounds of my practice I think almost no one escaped an attack."

An integral part of the life of the time, malaria received little more attention by many writers than the common cold does today. A writer described children with malaria thus:

". . . as we drew near Burlington [Iowa] in front of a little hut on the river bank, sat a girl and a lad—most pitiable looking objects, uncared for, hollowed eyed, sallow-faced. They had crawled out into the warm sun with chattering teeth to see the boat pass. To a Mother's inquiries, the captain said: 'If you've never seen that kind of sickness I reckon you must be a Yankee. That's the ague. I'm





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feared you will see plenty of it, if you stay long in these parts. They call it here the swamp devil and it will take the roses out of the cheeks of these plump little ones of yours mighty quick. Cure it? No, Madam, No cure for it: have to wear it out. I had it a year when I first went on the river'."

Ultimately, farm land drainage eliminated malaria from Illinois.

For the most part, the great infections headed the list of diseases that afflicted patients in the 1860s. Having enjoyed a grisly hey-day from earliest recorded history, they continued until the advent of the sulfanilamide-antibiotic period early in the forties. Diseases of aging played a minor role in the sixties; relatively few people became aged.

THE REMEDIES

How well equipped were physicians to combat disease? At the beginning of this decade, in 1860, the physician-poet, Oliver Wendell Holmes wrote:

"Excluding opium, which the creator, Himself, seems to prescribe, and excluding wine, which is a food, and excluding the vapors which produce the miracle of aneithesia, I firmly believe that if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes."

Just how did physicians treat diseases in those days? We are fortunate to have an early notebook dated 1858 belonging to a German physician, Dr. Aloysius Sieffert, who practiced in Evansville, Ind. Written in English, the book presents a fascinating picture of the way the early doctors combatted disease. Much of the therapy came amazingly close to the mark.

Take, for example, scurvy: Dr. Sieffert lists its treatment (as he does the treatment of most ailments) under five headings:

Dietetics
Astringents
Temperants
Tonics
Refrigerants

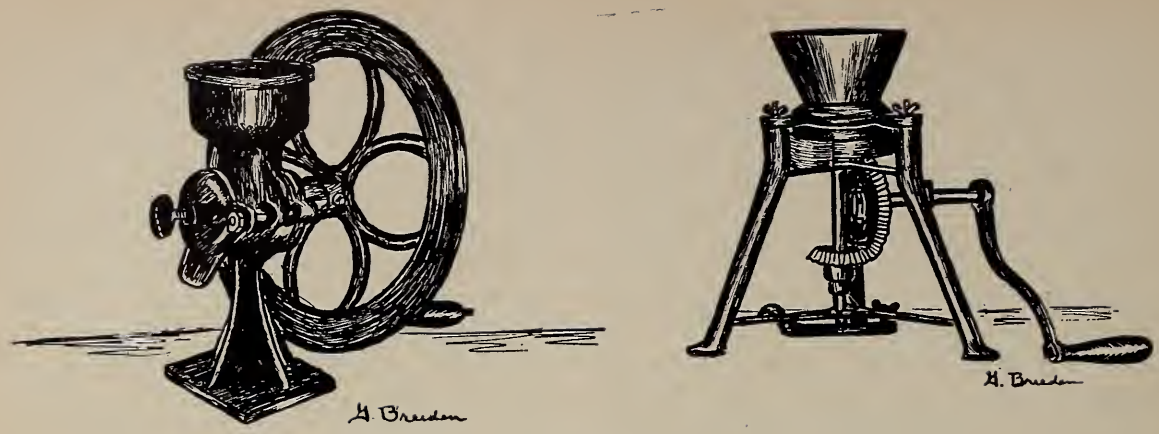
Under dietetics, we read: "... change of diet is the best; no animal-salted food but acid fruits: citrons, lemons, oranges and green vegetables: pickles, potatoes, sauerkraut, salad; cleanliness and pure air." Today we could scarcely improve upon that treatment. Under the heading of astringents, we see: "Mouth-washes of citric acid, of chlorate of potash, or oximel, vinegar and water." Under temperants, we find: "... acidulous drinks or fermented beverages: beer, cider, lemonade, oximalet; these are useful in acute or hot scurvy." Under tonics, Dr. Sieffert wrote: "In chronic or cold scurvy, cinchona, quinine, sulphuric elixir and tincture of Iron" are useful. Under refrigerants, he recommended: "... cold affusions or tipid ablution, cold mouth-washes and shower baths."

In his recommendations, Dr. Sieffert had much else that makes good sense today. Take the treatment of an insect in the ear canal: "... in the case of a living insect in the ear, a physician conceived the idea of asphyxiating the insect by means of chloroform. He dropped four drops of it upon a small piece of cotton which he introduced into the ear. Immediately, the pain ceased and an injection of warm water brought away a dead insect." He suggested this treatment for warts: "Three or four applications of chromic acid suffices to cause the disappearance of warts however hard and thick. The application causes neither pain, suppuration nor cicatrices, but the warts become of a blackish brown color. Chromate of Potassium grain 2, lard 1 ounce, mix well and apply to the wart twice a day; the wart will disappear in three weeks."

For itching, the good doctor recommended tepid baths or washings of flaxseed mucilage, starch water, soapsuds, and cleanliness. He added: ". . . the external or local treatment is seldom sufficient to cure the itch if the eruption is chronic or inveterate."

Of a special interest are Dr. Sieffert's recommendations for persons with mental ailments or "psychopathies:"

1. *Bleedings* when there is much vascular excitement or signs of cerebral conjestion
   - Venesection (that meant opening a vein)
   - Leeches to the temple or anus
2. *Refrigerants*
   - Cold applications to the shaved head
   - Cold shower bath or unexpected plunging into cold water



DRUG MILLS

Drug mills of various types were used to pulverize the coarser ingredients, such as herbs and barks from trees, for drugs. Both types shown can be adjusted to grind fine or coarse powder.

3. *Revulsives*
   - Blisters to the head
   - Setons (a hole made with a needle which was then kept open by running a thread or hair through it)
   - Actual cautery to the feet
4. *Derivatives*
   - Vomitives and purgatives repeated alternatively, especially when there is disorder of digestion
5. *Alternatives*
   - Nauseants—emetic or lavage
   - Bromides, mercurials or sustained mercurial courses
6. *Narcotics*
   - Full doses of opium or morphia
7. *Tonics* in long-protracted insanity to support the strength

(With the treatment prescribed under the first six categories, the patient would need a tonic)

These specific measures may not appeal to the modern physician, but on the next page, Dr. Sieffert discussed what he called psychiatria, or moral treatment: "A soothing, mild management; separation of the patient from his relatives; distraction; exercise; occupation; travail [meaning work]; music. The whole moral treatment can be reduced to the following indications:

"1. Never excite the ideas or passions of the patient on the subject of his delirium.

"2. Avoid direct contradictions of his erroneous opinions whether by jests or sarcasms.

"3. Draw his whole attention to the objects foreign to his folly.

"4. Communicate to his mind new impressions and sentiments by varied impressions."

Dr. Sieffert concluded:

"The care of the human mind is the most noble branch of medicine."

What were the drugs in Dr. Sieffert's armamentarium? We find carefully listed in his book, either individually or as part of prescriptions:

Arsenic	Digitalis	Lobelia
Atropine	Ergot	Podophyllin
Bismuth	Mercury	Quinine
Bromide	Iodine	Rhubarb
Chalk	Morphine	Santonin
Camphor	Opium	Strychnine
Cantharis	Oxalic acid	Sulphur
Cyanide	Ether	Veratrine
Calomel	Ipeca	

The War's Effect On Progress

The Civil War could not but heavily influence Illinois Medicine. Even though no major battles occurred in the state, its southern portion, Egypt and Little Egypt, abounded in Southern Sympathizers, since most of southern Illinois had been settled by people from Virginia and the Carolinas.

Sisters of the Holy Cross served selflessly in caring for wounded men during the War. They reported to young Gen. Ulysses S. Grant, serving aboard the hospital ship Red Rover and in 10 land-based hospitals. They remained in the Cairo area after the conflict and, in 1867, established an infirmary. Later this was enlarged to a hospital which still serves the community.

Most wars in history have made signi-

ficant contributions to medical progress. Was this true of the Civil War? We believe it was, but only to a limited extent.

Under the impetus of the War, surgery flourished, but for all the enormous battlefield experience, it remained shockingly crude. Surgeon Benjamin Howard advocated hermetic sealing of chest wounds, relieving the frightening breathlessness of chest wound patients by inserting a plug of lint held together and made airtight by coatings of collodion. A follow-up study of six cases showed 100 per cent mortality. Although opposed by the majority of doctors, one of the division hospitals of the Army of the Potomac adopted Howard's treatment.

Gen. Carl Schurz, a controversial but articulate Union general, described a typical operation at Gettysburg:

> "Most of the operating tables were placed in the open where the light was best, some of them partially protected against the rain by tarpaulins or blankets stretched upon poles. There stood the surgeons, their sleeves rolled up to their



AMPUTATION KIT

elbows, their bare arms as well as their linen aprons smeared with blood, their knives not seldom held between their teeth, while they were helping a patient on or off the table or had their hands otherwise occupied . . . a wounded man was lifted on the table, often shrieking with pain as the attendants handled him, the surgeon quickly examined the wound and resolved upon cutting off the injured limb. Some ether was administered and the body put in position in a moment. The surgeon snatched his knife from between his teeth . . . , wiped it rapidly once or twice across his blood-stained apron, and the cutting began."

If a wound miraculously escaped contamination, it faced the gantlet of repeated washings from a communal basin and sponge. The same sponge and basin of pus-filled water might contact every wound in a ward. Every operating location had its reeking pile of amputated parts; at one makeshift hospital, the heaps rose to the second story of the building.

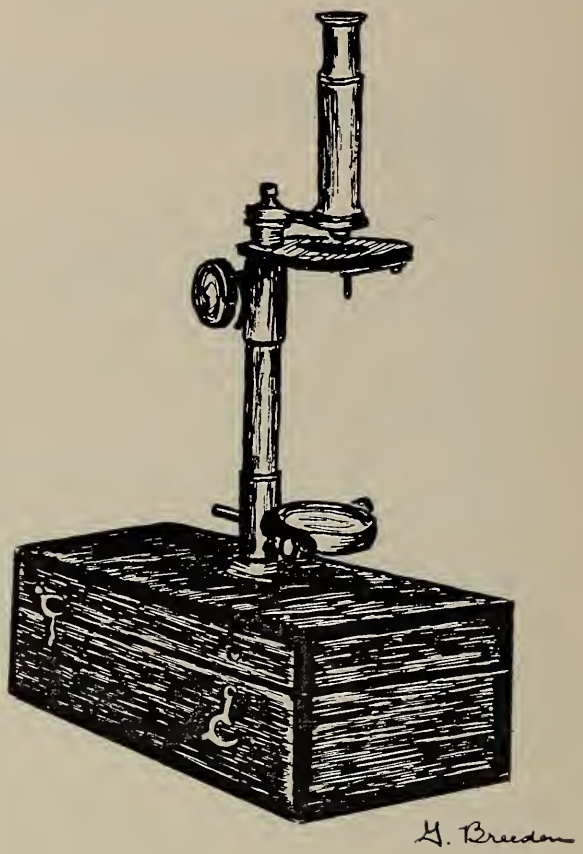
The military surgeon of 1861 employed not only carbolic acid but many other antiseptics, yet he used them too late, after permitting infections to reach horrifying bloom. Of course, doctors of the period knew nothing of the nature of infection or its communication.

Still, the War brought some improvements in medical care. Although primitive and inadequate at the outset, American ambulance and field hospital systems became models of their kind by 1865. The Union medical corps created a hospital system which became one of the wonders of the medical world. During the four years of the war, the general hospitals of the north cared for 1,057,523 soldiers with a mortality of only 8 per cent, the lowest ever recorded for military hospitals, even lower than in many civil institutions.

The Doctor's Bare Cupboard

During the sixties, disease presented a formidable picture, while the doctor's armamentarium to conquer ailments appeared shockingly inadequate. Yet doctors, usually the most learned men of the community, possessed high intelligence and strong devotion. To most, death was lighter than a feather and duty heavier than a mountain. Their rugged days, laced with searing heartbreak, began early in the morning, and continued often through the night.

Medicine, while a respected profession, existed mostly as an art with little science thrown in; too few facts had been scientifically established to form a basis for effective treatment. Such treatment had to wait until much more could be discovered. The patients could not wait; they sickened, they cried for physicians who could cure them; too frequently, they died. Patients longed for doctors, who were sure of themselves, and who believed their treatments



FIELD MICROSCOPE

Used by an Army physician during the Civil War, this microscope was carried in the small compact wooden box. When needed, it could be quickly fitted together and screwed into the top of the box.

worked. Someone said of one early surgeon of this period: "he had great force and positiveness of character . . . his professional convictions were absolute." Self-confidence remained a prime requisite for a successful practitioner through the sixties and long thereafter. Woe to the doctor who used his eyes and his intelligence, and saw that most of his remedies failed. Perhaps this was how the ponderous manner, the solemn dignity, the formalized behavior of the early physician developed. He looked

wise while examining a tongue. He consulted a ponderous watch while taking the pulse, perhaps he pretended to be calculating.

A Perceptive Picture

Over the ages, poetry has often surpassed prose as a medium of description. Indiana had a physician-poet during the 19th Century, Dr. James Newton Matthews, member of the Marion County Medical Society and friend of James Whittcomb Riley. He read one of his poems, *Ballad of the Busy Doctor,* at a banquet of his county medical society in the year 1888. It presents a somber but amazingly perceptive view of the doctor's lot in a small Midwestern town during a 19th Century winter. And while it was written by a Hoosier doctor, about a Hoosier town, it applies just as well to Illinois:

Ballad of the Busy Doctor

"When winter pipes in the poplar tree,
And soles are shod with the snow and sleet—
When sick-room doors close noiselessly,
And doctors hurry along the street;
When the bleak north winds at the gables beat,
And the flaky noon of the night is nigh,
And the reveller's laugh grows obsolete,
When Death, white Death, is a-driving by.

"When the cowering sinner crooks his knee
At the cradle side, in suppliance sweet,
And friends converse in a minor key,
And doctors hurry along the street;
When Croesus flies to his country seat,
And castaways in the garrets cry,
And in each house is a 'shape and a sheet,'
Then Death, white Death, is a-driving by.

"When the blast of the autumn blinds the bee,
And the long rains fall on the ruined wheat,
When a glimmer of green on the pools we see,
And doctors hurry along the street;
When every fellow we chance to meet
Has a fulvous glitter in either eye,
And a weary wobble in both his feet,
When Death, white Death, is a-driving by.

ENVOY

"When farmers ride at a furious heat,
And doctors hurry along the street,
With brave hearts, under a scowling sky,
Then Death, white Death, is a-driving by."

OXYGEN THERAPY

The serious consequences of ventilatory depression by oxygen therapy are well known and can be avoided by the proper use of the masks in patients with chronic pulmonary disease. It is not commonly appreciated, however, that their use is contraindicated in certain types of respiratory failure also associated with progressive respiratory acidosis. These are clinical situations in which Alveolar carbon dioxide tension can rise significantly during oxygen therapy, not as a result of ventilatory depression but simply because the underlying disease has become worse. For example, in some patients with intractable asthma who are receiving high inspired oxygen concentrations progressive, severe respiratory acidosis develops, not because of decreased ventilatory effort but as a result of continued increase in airway resistance. Under these conditions, fatal hypoxia may ensue if the rise in alveolar carbon dioxide tension is misinterpreted as evidence of ventilatory depression and the inspired oxygen concentration is therefore not kept at a high level. (Mithoefer, J. C., etal; New England Jl. Med. (Nov. 2) 1967.)



HAY FEVER INJECTIONS

A group of New York pediatricians made a five-year study on the effectiveness of immunization in the prevention of hay fever. The injections were given prior to the pollination season which is in late August. An equal number of children received a placebo that was similar in appearance but lacking in ragweed extract. Some beneficial results were noted among those receiving the ragweed extract but the improvement in this group as compared to the control group was not significant.

Similar studies on allergic adults with a variety of sensitivities are somewhat more encouraging because those receiving the extract derived more relief. In other words, the value of allergen injections is being questioned and time will tell whether the plan has as much merit as we have been led to believe.

In many of these experiments the response to desensitization varied considerably with the individual and the year they received the injections. Prevention is difficult when the pollen count is excessive due to favorable weather. When the season is mild we are likely to give the ragweed extract more credit than it deserves.

It also is difficult to explain why so many receiving the placebo are helped. Both groups have access to other anti-allergy remedies such as the antihistamines, steroids, decongestants, and filters. In addition some persons are more sensitive than others to ragweed pollen and begin to sneeze when the pollen count is relatively low. Rest, peace of mind, and co-existing allergies also play a role in hay fever. Therefore, it is not easy to evaluate the effect of an allergy preventive.

The investigators found that the skin tests of those receiving the ragweed extract for three consecutive years were developing immunity. This was encouraging except that many continued to sneeze and complain of nasal congestion and other ragweed symptoms despite the favorable skin tests.

T. R. Van Dellen, M.D.

References

Effectiveness in Hyposensitization Therapy in Ragweed Hay-Fever in Children. Vincent J. Fontana, M. D., L. Emmett Holt, Jr., M.D., and Donald Mainland, M.D. J.A.M.A. 195:12 (Mar. 21) 1966, pp. 985-992. (Also in letters to the editor-same issue—Hyposensitization Therapy in Ragweed Hay Fever, J.A.M.A. pp. 1071-1072.)

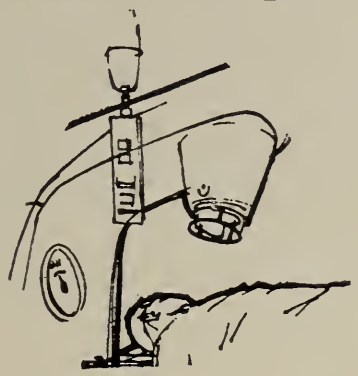
Subdural hematomas are common in pediatric age groups, particularly in infants and children under the age of two years. The frequency is notably diminished in older children and adolescents, in fact the latter group has the lowest incidence of all age groups.

It is the etiology of subdural hematomas which accounts for the wide discrepancy between the age groups. Some of the causes are worth recapitulation:

1. Traumatic birth;
2. Carelessness in handling infants;
3. Accidents, such as falling in the case of toddlers, bicycle or playground accidents in older children;
4. Accidents incidental to our motorized age.

All of these take their toll and present either acute or chronic subdural hematomas.

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

Medical Progress in the Care of Subdural Hematomas In Infants And Children

BY C. LUIS-PORRAS, M.D., AND L. V. AMADOR, M.D./CHICAGO

This study excludes newborns. Therefore, our cases range in age from two days to the late teenage group. The total number of these cases was 76. The interesting feature about them is that there are different clinical manifestations in this group when compared to adults with subdural hematomas.

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Luis V. Amador, M.D., is Associate Clinical Professor of Neurological Surgery, the Univ. of Illinois College of Medicine, as well as attending neurosurgeon at St. Joseph's, Children's Memorial and Lutheran General Hospitals. He is a graduate of the Northwestern School of Medicine and served his internship at St. Lukes, Chicago. Post graduate studies were completed at the Neuropsychiatric Institute, and under the auspices of the Rockefeller and the Guggenheim Foundation.

Before mentioning the different signs and symptoms in infants and children, it is helpful to bear in mind the patho-physiology involved. By definition, a subdural hematoma is an accumulation of blood from ruptured blood vessels which collects in the subdural space. This lesion is generally classified as acute or chronic. It has been suggested by McKissock[10] that three types of hematomas may be differentiated, based on a temporal classification: acute (up to three days), subacute (4 to 20 days) and chronic when the hematoma is more than twenty days old.

In addition to subdural hematomas, there is another entity, sometimes found in the subdural space, known as a hygroma. This is a lesion which consists of serous fluid in the subdural space. Such fluid may be either clear or colorless. In chronic cases the fluid may become xanthochromic and the entire lesion surrounded by a neomembrane. Two theories have been proposed to explain hygromas. Primarily that it is

due to traumatic laceration of the arachnoid followed by peripheral pulsations of cerebral spinal fluid with a secondary accumulation of fluid; or secondarily, that it is a primary effusion of fluid into the subdural space. The exact mechanism of such is not understood. The term subdural hygroma and hydroma are synonymous. A significant fact, however, is that a subdural hematoma and hygroma may co-exist. With minor differences symptoms and signs of these two are essentially the same, hence their distinction is primarily pathological, and the following discussion applies to both entities.

Subdural hematomas most often occur over the upper portion of the parietal and frontal regions, and frequently may be found bilaterally. Size of the hemorrhage varies in extent and amount. Cerebral cortex is depressed in proportion to the quantity of accumulated blood.

Pathology of Acute Subdural Hematoma

Fresh bleeding beneath the dura almost always occurs as a result of severe head injury. Often there is an associated laceration, contusion and edema of the brain. These lesions may also occur secondary to a closed injury, at which time there is tearing of the veins crossing the subdural space with secondary displacement of the brain within the skull. They may occur as a result of a depressed or compound fracture associated with laceration of the cerebral veins and sinuses. Other forms of hemorrhage such as subarachnoid, intracortical, or epidural may be present simultaneously.

Although medical literature sporadically reports subdural hematoma related to dehydration, scurvy, rupture of congenital vascular anomalies, blood dyscrasias, and bleeding associated with a brain tumor, we have not observed any of these phenomena in our series of cases.

Pathology of Chronic Subdural Hematoma

The most characteristic feature of this form is that there is usually an interval varying from a few weeks to a few months between the occurence of trauma and the appearance of symptoms and signs. Often the patient will have had an incidence of head trauma which cannot be recalled, due to post traumatic amnesia.

Acute subdural hematoma obviously consists of a pool of blood under the dura. The collection of blood after several weeks usually becomes completely encapsulated by a membrane of connective tissue. In this early stage a capsule is not well defined. It usually does not become adherent to the arachnoid presumably because the layer of exothelial cells, at the surface of the arachnoid, prevents attachment.[5] These cells do not react to the blood in the same manner as do the inner layers of the dura. Small sinus-like vessels are present from dura to capsule. The arachnoid is usually stained yellow by blood pigments, and there is a deposition of collagen fibers which result in a tough outer membrane. The inner membrane is almost always thinner. The contents of the subdural sac consist of either a dark red thick fluid or dark yellow fluid with high protein content. Numerous red blood cells in varying degrees of disintegration may be observed. With the passage of time the breakdown of the hemoglobin products result in a fluid which tends to become red-yellow, then ultimately amber.

Analysis of Cases

In the series of 76 cases presented in this paper all were diagnosed by either subdural taps, ventriculography or angiography. In some patients more than one diagnostic procedure was necessary. All cases were verified by subdural taps, burr holes or craniotomy. These cases have been admitted on the service of one of us (L.V.A.) over the years 1951-1966. In the series 45 patients were boys and 31 were girls. Because of the differences in signs and symptoms in infants and young children when compared to older children, the cases have been divided into two groups; the arbitrary dividing line has been two years of age.

Signs and Symptoms

The findings which we have recorded are those noted on initial examination. In evaluating the percentage of symptoms and signs it became apparent that some of the neurological observations appeared to be different than those commonly cited in the literature. We were fortunate that referring pediatricians and family physicians recognized the symptomatology of subdural hematomas promptly. Therefore, patients were admitted early in their clinical course.

In the group of infants and children

under the age of two years there were 63 cases. Of these patients, 33 had bilateral hematomas. We noted that convulsions occurred in 38% of the patients, vomiting in 32%, tension of the fontanelle in 24%, enlarged head in 19%, associated fracture of the skull in 19%, lethargy in 13%, irritability in 11%, retinal hemorrhage in 10%; hemiparesis, fever, anorexia and involvement of the extra ocular musculature occurred in less than 10% of our patients. There is a variance with our series of patients when compared with other series in the neurosurgical literature. Such reports indicate that convulsions occurred in 45% of patients, vomiting in 40%, hyperthermia in 40%, tense fontanelle in 35%, irritability in 35%, enlargement of the head in 25%, retinal hemorrhages in 20%, lethargy in 15-20%, linear fracture of the skull in 15-20%.

In those children over two, this series of cases includes only 13 patients. Among these one third had bilateral hematomas. Therefore the percentages of incidence may be at variance with the experience of other neurosurgeons. We found that in these patients coma occurred in 35%, lethargy in 30%, headaches in 50%, vomiting in 30%, fracture of the skull in 30%, papilledema in 20%, hemiparesis in 20%, decerebrate signs in 16%, neck stiffness in 16%, and convulsions, sixth nerve palsy and retinal hemorrhages in one percent.

Laboratory Studies in Infants and Children Under Two Years Age

It was impressive to note that anemia occurred in 38%; also, that in some patients the hemoglobin was as low as 5.8 grams. White blood count demonstrated a relative leucocytosis in 36% of the cases. In one patient the white blood count was elevated to 43,000 cells per cu. mm. In the very young age groups there was a predominance of lymphocytes.

Only seven patients required spinal puncture. Analysis of these revealed bloody fluid in one, xanthochromia in four and clear fluid in two. Drainage or subdural taps were performed in sixty-three patients, and in all of them fluid was either bloody or xanthochromatic. Total protein was elevated; in one case it was 1850 milligrams percent.

Laboratory Studies in Children Over Two years of Age

In contrast to the above group, only one patient was anemic, having a hemoglobin of only 8.6 grams. White blood count demonstrated leucocytosis in 32% of cases, and again when contrasted to the younger age group, the findings were those of a predominantly polymorphonuclear cell increase.

Cerebral spinal fluid studies demonstrated xanthochromia in two cases, blood in one. As a rule we do not utilize lumbar puncture in suspected subdural cases. In three of the patients, however, there was some degree of doubt as to the possibility of a meningitis. Therefore, a spinal puncture was performed as an added investigative procedure.

Diagnostic Procedures

Skull x-rays were abnormal in 50% of the cases under two years of age. These findings consisted of fractures in 19% of these infants, enlargement of the head in 18%, and calcification of the hematoma in five percent.

In the older age groups 30% of the patients demonstrated fracture of the skull.

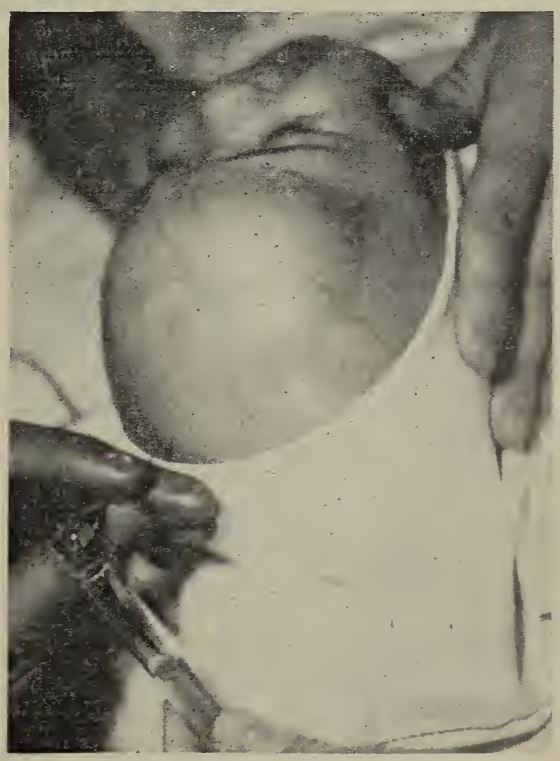


Fig 1. Subdural tap in an infant. Needle inserted at lateral border of anterior fontanelle.

Other abnormal changes were not usually detectable. In the series of 13 patients we found a skull fracture in twenty-one percent. A "growing fracture" (a widening fracture secondary to arachnoidal pulsations) was observed in two patients.

Cerebral angiography is of limited value in the infant and generally is not necessary because of the ease by which the diagnosis can be established through subdural taps (Fig. 1) and air studies (Fig. 2). Nonetheless, in the older age group cerebral angiography is of considerable value in the diagnosis of subdural hematoma (Fig. 3,4).

Echoencephalography may also be of assistance in detecting the presence of a subdural hematoma due to a shift of the brain. Moreover, this procedure is a helpful technique in determining growth and expansion of the blood clot. It should be noted, however, that bilateral subdural hematomas are exceedingly difficult to differentiate by this technique.

Electroencephalography is of limited value and was performed in only three of the older children. Of these three, two demonstrated bilateral hypoactivity, and one was inconclusive. We did not use elec-

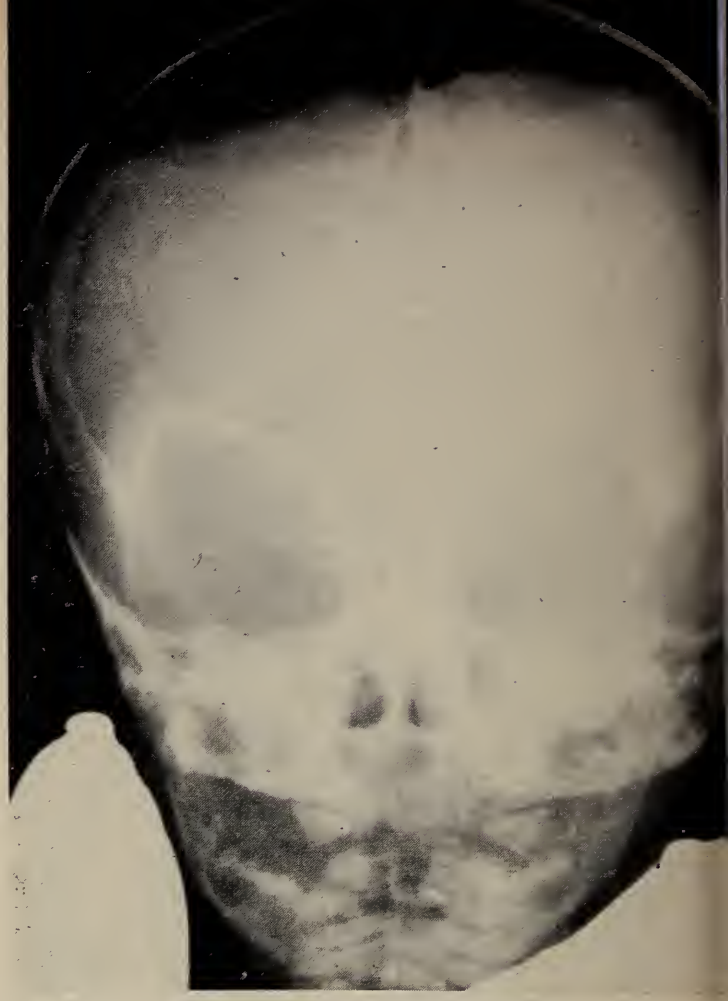


Fig. 2. Air study utilized to outline subdural hematoma.



Fig. 3. Subdural Hematoma outlined by cerebral angiogram. Note avascular space between cerebral cortex and skull.



Fig. 4. Angiographic demonstration of subdural hematoma (early venous stage.). Note extent of lesion.

troencephalography frequently because in acute head injuries, and particularly in those cases which have cephalohematomata or scalp lacerations, it is very difficult and at times impossible to apply scalp electrodes satisfactorily.

Treatment

It has been our policy to drain the hematoma in infants by means of subdural taps at daily intervals. Only a few cubic centimeters of blood should be removed in order to prevent rapid shift of brain contents. When the taps are dry and continue to be so after 2 or 3 days we assume that, in most cases, the hematoma has been evacuated.

In persistent subdural hematoma, i.e. those patients in whom the taps continue to reveal bloody fluid after two weeks, we perform a craniotomy on the appropriate side. The bone flap should be large enough to gain access to the involved regions. This enables the entire cortex to be visualized, and an attempt should be made, not only to drain and irrigate the hematoma, but also to remove membranes. These are usually stripped from the dura by utilizing a curved periosteal elevator. The membrane over the cortex must be gently lifted from the arachnoid. Ordinarily there is excellent cleavage and little difficulty is encountered. Should there be any adhesions it is better to leave the adherent membrane attached to the arachnoid rather than damage overlying cerebral cortex. We are in disagreement with those authors who feel that only drainage, or conservative managment, is sufficient to remove the dangers of a subdural hematoma. We believe that a hematoma is a potentially serious lesion. The mass should not only be drained but an effort should be made to remove any constricting or potentially constricting membranes on the brain surface. We can see little advantage in leaving such a membrane over the cerebral cortex and can see some harmful consequences, such as: epileptogenic focus, vascular impairment to cerebral cortex, possible brain constriction.

In the older age group, diagnosis and management of a subdural hematoma is basically that of removal of a mass lesion. Diagnosis may be established in one of several ways: echoencephalography, cerebral angiography, air studies. When the lesion has been accurately outlined it is possible to make one or two burr holes over the edge of the hematoma and to drain if in a liquid state. Burr holes may be diagnostic as well as therapeutic. If there is a clot, or membrane, we use the same technique as previously described for infants and younger children.

In a small number of cases, consisting of both groups, we have encountered a persistent subdural hygroma associated with subdural hematoma. The exact mechanism for formation of this fluid is unknown. Because of continued compression of cortex by the persistent fluid accumulation there is danger of brain damage. Therefore it has been our policy to insert a low pressure (10 mm) shunting system from the subdural space to the venous system or peritoneal cavity to drain the persistent fluid. Our results with such a procedure have been excellent.

Results

More than ninety percent of the 76 patients survived drainage or surgery; 81% of these had no sequelae following treatment. It should be borne in mind that these statistics are all the more remarkable since patients included seriously injured infants and children, some of whom had multiple trauma.

The mortality rate was 9.5% in this serices. In the group under two years of age 4 patients (15%) expired, three had traumatic laceration of the brain with extensive damage, and one other patient died from pneumonitis. In the group over two years of age three patients (20%) died. Two of these had both laceration and extensive trauma of the brain; the other patient died from septicemic pneumonitis.

Sequelae

In the group under two years of age approximately eight percent developed symptoms and signs of residual involvement of the central nervous system. Some children had more than one complication. These consisted of: hemiparesis (three patients), cerebral atrophy (three), convulsions (one), sixth nerve palsy (one), subdural effusion necessitating shunting procedure (two patients).

In the group over two years of age, 5 patients (36%) developed residual symptomotology consisting of the following: hemiparesis in two, cerebral atrophy in one, convulsions in two patients.

Follow-up Study

Repeated observations have been made on the fifteen patients with sequelae. It has been noted that in the group under two years of age, out of the three hemiparetic patients two showed a definite improvement, while one patient was lost from the clinic roster. The patient who had convulsions during hospitalization has been seizure free while on medication. The child with the sixth nerve palsy recovered in several months. One of the patients with a shunt has been followed for 1½ years, and, fortunately, increased intracranial pressure has been adequately controlled without further valve revision. The other patient did not return to the clinic.

In the age group over two years there were two hemiparetics. One improved over the period of a year and a half. The other was unchanged at the end of one year, but, unfortunately, could not be evaluated in the 18 month period because he did not return to the clinic. Two patients with convulsions were followed for one year—one is symptom free and continues on anticonvulsants, the other has had some convulsions in spite of medication. The remaining four patients present no significant change in their symptomotology.

Commentary

Subdural hematomas are found three times as frequently in infants and young children as they are in the older age groups. There are several factors which may explain this increased incidence. The head is proportionately larger in reference to body size in infants and young children. This factor may be conducive to greater incidence of head injury. It is particularly true in the patient learning to walk. The skull is more plastic in the infant and young child and, therefore, greater stress upon the cerebral cortex, veins and sinuses probably is transmitted by an injury, when compared with the heavier skull of the older age group. Furthermore, we believe that young children who have less experience in running and walking will be less able to protect themselves from injury as they fall.

Location of a subdural hematoma is usually in the parietal area. In our experience 60% of all lesions were in this region. It is our feeling that multiple factors may contribute to such high incidence. First of all, veins are delicate, especially bridging veins spreading over the vertex of the brain. Secondly, fractures are usually in the frontal-parietal area, and consequently exert a great deal of stress upon these vessels. Finally we must consider that the brain fits more snugly in the lower half of the skull than it does under the vertex. It is, therefore, conceivable that oozing from torn bridging veins would be more limited to the area of the frontal-parietal regions than it would be to the lower part of the brain. We believe that this could be due to resistance of blood seepage as it accumulates at the site of the torn vein.

In 50% of the cases it was noticed that the subdural hematomas were bilateral. Perhaps shifting brain and the contre-coup theory explain torn veins at a distance from the primary point of impact. In some of the cases the hematoma was actually found on the side opposite a fracture!

It has been common knowledge that infants present different signs and symptoms than older children. This is believed to be due primarily to head configuration of the older group and paucity of cartilaginous skull. In addition, the compensatory mechanism, consisting primarily of large open sinuses, alters development of increased intracranial pressure in an infant compared to older children.

Summary

Results are considered excellent. Approximately 90% of patients survived surgery. Mortality is approximately ten percent. It is greater in the acute head injury, which so often has been associated with laceration of the brain and tears of large veins and sinuses. Naturally, such a head injury is more serious and the mortality rate is higher. Sequelae from head injuries associated with subdural hematoma are primarily the result of brain compression and associated injury from head trauma. These findings consist of atrophy of the brain, convulsions, mental retardation and other neurological deficits.

In conclusion, therefore, prompt recognition of subdural hematomas in infancy and childhood is of the utmost importance. If this is accomplished such lesions can be treated satisfactorily and excellent end results are obtained.

(Continued on page 204)

Avulsion Perineal Injury

A Case Report of Avulsion of Skin of Penis and Scrotum

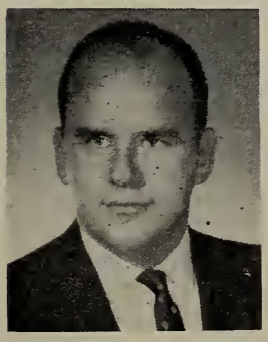
ARTHUR D. POPPENS, M.D.,
GEORGE E. GIFFIN, M.D.,
AND LOUIS D. TARSINOS, M.D., F.A.C.S.
/PRINCETON

Machinery injuries of a very disabling nature have become increasingly common both in industry and agriculture. By virtue of geographic location, agriculture injuries are somewhat more common in our community than those of an industrial nature. Many of the injuries that are seen in the area involve trauma to various portions of the extremities of the patient. In particular, crushing injuries and avulsive injuries of various kinds are common. Compression injuries, likewise, are seen with increasing frequency as various types of feed grains are compressed for purposes of decreasing space required for storage. Additional factors in the increased incidence of injuries has been the advent of the "power take-off" which is simply a power shaft from the tractor to the machinery concerned, thereby eliminating the requirement for a power source in the machine itself. This is a case of an unusual type of injury which resulted from involvement with such a power shaft.

Traumatic Illness

Patient N.N., age-49, was standing astride a protective covering of a power shaft when he slipped and fell so as to straddle the power shaft. At the same time the power shaft picked up a free edge of the trouser leg on one side and ripped off this material with great force and also pulled the patient against the power shaft with great force. The continuing injury somehow caught the loose scrotal skin and also the skin of the penis. This rapidly avulsed the skin from the entire scrotum and penis and produced a deep laceration of the perineum which extended from an area slightly above the pubis in the lower abdomen down and around the penis and then through the perineum into the rectal muscle without penetration of the rectal mucosa. There were additional injuries due to abrasions and contusions of the legs and abdomen as well as a laceration of the ear which resulted from the patient's head being pulled down close to the power shaft.

The patient was taken to the hospital and suffered moderate blood loss after the injury and during transportation. On examination at the hospital, there were multiple abrasions and contusions of the trunk and extremities as well as a laceration behind the right ear and a small lacer-





Arthur D. Poppens, M.D., left, is a general surgeon in Princeton. He is a graduate of Northwestern University School of Medicine and served his internship and residency at Cook County Hospital. George E. Giffin, M.D., ISMS Trustee from the 2nd District in 1967-68, is a graduate of the University of Illinois School of Medicine. He served his internship at St. Mary's Hospital, Saginaw, Mich., and is Currently on staff at Perry Memorial, Princeton. Louis D. Tarsinos, M.D., right, is attending urologist at Perry Memorial Hospital in Princeton and St. Margaret's Hospital in Spring Valley. He served his interneship at Alexian Brothers Hospital, Elizabeth, N.J. and a residency at Martland Medical Center, Newark, N.J. He is a graduate of University of Athens, Athens, Greece.

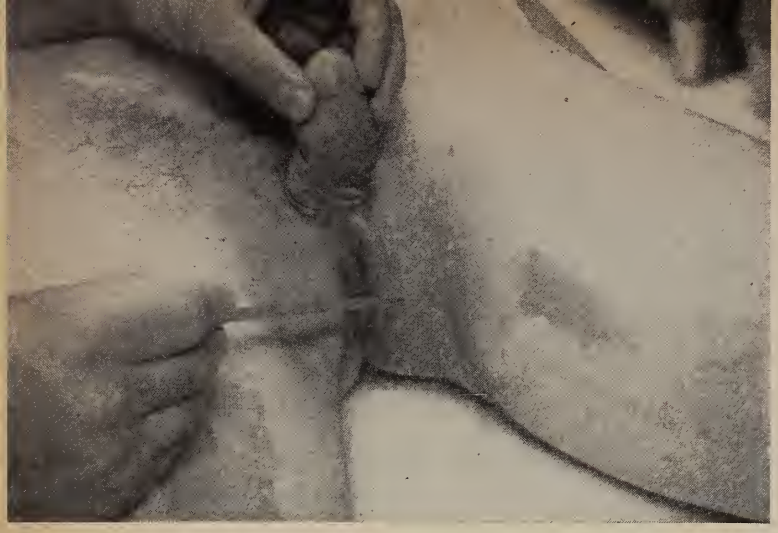


Fig. 1. **Left scrotal contents placed under the skin of the thigh.**

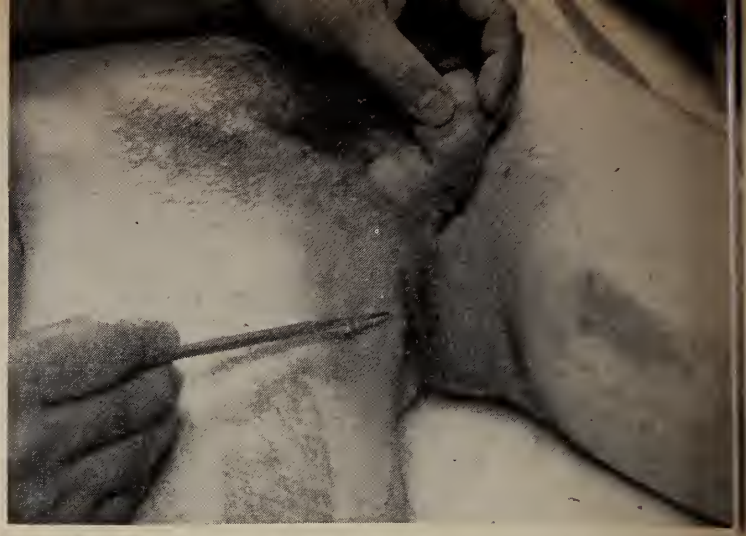


Fig. 2. **Right scrotal contents placed under the skin of the th**

ation above the right eye. There was complete loss of the skin of the scrotum and skin of the proximal portion of the penis. There was a small flap of skin around the coronal sulcus. There was a deep laceration as noted above in the description of the present illness. There were in addition, puncture wounds of the left thigh, some four inches distal to the site of perineal laceration. However, the penis and testicles and cords were lying free with no compromise of the vascular supply of the testicles. All wounds were very dirty and contained evidence of grass and other debris from the field.

The patient's management consisted primarily of immediate determination of the status of the patient's blood count and immediate cleansing of the wounds and evaluation of the status of the patient. In as much as the scrotal and penile skin were completely gone, it was elected to transplant the testicles to the thigh.

This procedure was done and a few loose sutures were used to secure the testicles in position. A primary split thickness skin graft was then elevated from the thigh and used to cover the penile shaft. The laceration which extended from the suprapubic area to the anus was closed in stages as this repair of the penis was completed. Drainage was provided for the entire area through the previously established traumatic stab wound of the left thigh. All additional injuries were then treated and loose dressings applied throughout.

On admission, the patient's blood count and urinalysis were: W.B.C. 13,000; Hemoglobin 16.3 gms.; Hematocrit 45.3%. Differential showed 52 polys, 4 stabs, 1 eosin, 42 lymphs, 1 mono; patient was A positive. Urinalysis findings the following day were 1 plus albumin, 1 plus acetone, 2 to 3 W.B.C.

Uncommon Injury

Injuries of the scrotal and penile skin are still uncommon, though they are being encountered with increasing frequency as industry expands and farming becomes more mechanized. Scrotal avulsion is, without exception, an industrial injury. A farmer straddles or leans against his tractor belt to line it up while starting, or a mechanic steps too close to a whirling power belt or an unguarded set of gears. Trousers are caught, and in an instant they are gone, together with most of or all of the genital skin, sometimes one or both testes, and on rare occasions, the penis itself. Complete avulsion leaves the testes exposed and the penile shaft bare, each of which presents its own particular problem.

It is imperative that the man not be left desexed if preventable.

Whatever the type or degree of penile injury, it is of paramount importance that everything possible be done to preserve both its structure and function. Sex stands very high among the most precious powers of men and its loss is never taken lightly. The power of useful erection and its ability to void in a manly fashion are functions of utmost importance and their preservation should be the prime purpose in the management of all penile injuries.

The purpose of this paper is to present and emphasize the successful preservation of both the testicles and penis, the restoration of urination and sexual ability, and the cosmetic results of the plastic repair.

Fig. 3. Skin graft to the base of the penis after complete healing. Notice the minimal scarring on the dorsal aspect of the penis and donor areas on thighs.





Fig. 4. Complete healing of the perineum after removal of the scrotal contents. The penis can be retracted upwards without any difficulty. This will provide a normal erection.

Fig. 5. This picture illustrates a normally appearing penis after a skin graft done for complete avulsion of the penis and the scrotum. The patient had a satisfactory anatomical and functional result.



Comment

The patient presented here showed a good recovery from his injuries. The wounds healed primarily and the skin graft of the penile shaft was accepted in its entirety. There is continuing tenderness of the testicles in their new position in the thigh but the patient's potency is restored and he states that he is able to undertake normal sexual relations with ejaculation. A certain amount of expected psychic effect has resulted and the patient has considerable anxiety and mild phobias about his general condition. He has episodes of lower abdominal pain which seem best to be related to some tension on the spermatic cord. His physical status is very good and it is anticipated that further improvement will occur in his psychic state.

Results in an Urban Private Psychiatric Practice

By Paul Miller, M.D./Chicago

Dr. PIPP—the Psychiatrist in Private Practice—is more of an enigma to his fellow physicians than any other medical specialist. The reason is that most non-psychiatric physicians have not directly observed Dr. PIPP's work, nor have they been able to review the outcome of psychotherapy, since no Dr. PIPP has ever published a description of all his patients and the results of their treatment over a period of several years.

This report is the *first* description of all the patients of a typical Dr. PIPP. Two recent studies[1,2] indicate that the author is similar to the "average" urban psychiatrist in private general psychiatric practice, who typically spends 30-35 hours a week seeing private patients, sees about 33 different individuals each month, sees most of his patients in once-a-week psychotherapy, uses drugs for a selected minority of patients, does not see neurological patients, and spends his other professional time in teaching, in research, and in public clinics and hospitals.

This author has collected data in 52 different areas for each patient since he began private practice in 1960. Information has been transferred to IBM punchcards. Data presented have been chosen for their interest to the general medical reader; they represent only a fraction of all data collected.

The Patients

During 1960-1964 the author saw a total of 157 patients. Of these, 139 (89%) were evaluated for psychiatric treatment. The remaining 18 (11%) were referred for other services, including counseling about a specific situation (such as divorce), advice about a disturbed relative, and determination of legal competency. Table 1 lists the sources of their referral (no psychiatric patients are "walk-ins"). Table 2 indicates the disposition of the 139 patients referred for psychotherapy. Table 3 summarizes the basic characteristics of patients referred for psychotherapy.

Table 1

Sources of Referral of 157 Patients

Medical	84%
Non-psychiatric MD (42%)	
Psychiatrist (32%)	
Medical clinic (10%)	
Non-medical	16%
Clergyman (4%)	
Lawyer (4%)	
Former patient of author (4%)	
Self-referred student of author (2%)	
Non-medical psychotherapist (1%)	
College mental health center (1%)	

Table 2

Disposition of 139 Referrals for Psychotherapy

Psychotherapy Not Recommended	9%
Psychotherapy Recommended, Patient Refused	12%
Psychotherapy Recommended, Patient Accepted	79%
Treated by the author (68%)	
Referred to another psychotherapist (11%)	

Table 3

Basic Characteristics of 139 Patients Referred for Psychotherapy

Age	Mean	35.2 years
	Range	14-78 years
	Distribution	
	14-19	12%
	20-29	27%
	30-39	31%
	40-49	14%
	50-59	10%
	60-69	5%
	70-78	1%
Sex	Male	47%
	Female	53%
Religion	Protestant	41%
	Catholic	27%
	Jewish	20%
	None	12%
	Activity	
	Practicing	46%
	Non-practicing	54%
Marital status of 116 adults		
	Never married	22%
	Married and living with spouse	59%
	Once married but now living alone	19%

The marital status of adult patients was unstable: for every five patients, only three were married and living with their spouse; one had not married, and the other—although married in the past—was not living with a spouse.

Table 4

Social Class Factors (No.=139)

Social Class	
Class I.	13%
Class II.	24%
Class III.	41%
Class IV.	15%
Class V.	4%
Undetermined	3%

Education	Head of Household	Patient
Graduate degree	14%	11%
College degree	29%	25%
Completed 1-3 years of college	22%	29%
High school graduate	16%	16%
Completed 2-3½ years of high school	12%	17%
Completed 8-9 years	1%	1%
Undetermined	6%	1%

Occupation	Head of Household	Patient
Higher executive; major professional	19%	12%
Manager; proprietor; lesser professional	24%	9%
Administrative personnel; small businessman; minor professional	30%	20%
Clerk; salesman; technician	14%	13%
Skilled manual employee	5%	1%
Semi-skilled employee	2%	1%
Unskilled employee	1%	1%
Undetermined	5%	0%
Student	0%	16%
Housewife unemployed outside home	0%	22%
Unemployed and not a student or a housewife	0%	5%

Table 5

Annual Income of Head of Household (No.=139)

0-$3500	4%
$3600-5000	12%
$5100-7500	30%
$7600-10,000	24%
$10,000 and up	26%
Undetermined	4%

Table 6

Initial Psychiatric Diagnosis (No.=94)

Psychoneurotic Disorders	32%
Personality Disorders	45%
Personality trait disturbance (25%)	
Personality pattern disturbance (16%)	
Sociopathic personality disturbance (4%)	
Schizophrenic Reactions	23%

Table 7

Symptom Problem Areas (No.=94)

Area	Primary Area	Secondary Area	Total
Marital Conflict	18%	16%	34%
Depression	17%	17%	34%
Confusion of Self-Identity	11%	22%	33%
Lack of Impulse Control	20%	4%	24%
Somatic Complaints	9%	9%	18%
Sexual Difficulties	9%	9%	18%
Disturbed Interpersonal Relations	6%	10%	16%
Nonspecific Dissatisfaction with Life	2%	7%	9%
Difficulty with Parents	4%	4%	8%
Anxiety	4%	2%	6%

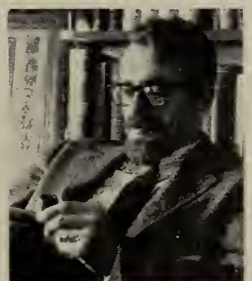
Table 4 summarizes social class factors. The "Two Factor Index of Social Position"[3] was the scale used; it yields five social classes, using the two factors of the education and the occupation of the head of the household. The table shows that the upper classes were over-represented and the lower classes were under-represented. Both patients and heads of households were well educated and were high occupational achievers. Table 5 lists the annual income of the heads of households of patients. The median income of $7900 was approximately the same as the median income of families in Chicago.

Initial Phychiatric Evaluation

The remainder of the Tables describe the 94 patients who undertook psychotherapy with the author.

Table 6 gives the initial psychiatric diagnosis. All patients referred for psychotherapy had a diagnosable mental disorder, a finding that refutes critics[4,5] who say that most highly trained psychotherapists treat "garden-variety distress or unhappiness" and "therefore, have less time for that similar number of truly neurotic and psychotic patients who need their specialized skills."[4]

Most physicians are familiar with psychoneurosis and schizophrenia but know less about personality disorder. It is "characterized by developmental defects or pathologic trends in the personality structure. . . . manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms."[6] In general it is more severe than psychoneurosis and less severe than schizophrenia.



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Organic disease is not represented, because patients with known brain disease are rarely referred to this author by his colleagues; if they are, the author immediately refers them to a neurologist.

Table 7 details the symptom problem areas. After completing the diagnostic survey (a minimum of two interviews), the author chose which areas were the first and second areas of patient problems.

Table 8

Grades of Anxiety and Depression (No.=94)

Anxiety	
None	0%
Slight	2%
Some	16%
Moderate	22%
Moderately severe	40%
Severe	12%
Disabling	8%
Depression	
None	2%
Slight	5%
Some	17%
Moderate	26%
Moderately severe	28%
Severe	13%
Disabling	9%

Table 8 records grades of anxiety and depression among patients. The process of rating levels of affect from a clinical interview has been established as reliable and valid.[7,8] Although grades of anxiety were slightly higher than depression, patients complained of much more depression than they did of anxiety (Table 7). Probably depression is the more painful subjective experience. One study[9] found that depression is basically the same as anxiety with the added dimensions of strong feelings of helplessness and hopelessness. It is these added feelings which make depression more painful to the patient.

The Process of Psychiatric Treatment

As a psychodynamically (or "psychoanalytically") oriented psychotherapist, the author views his work as follows. He and the patient meet at regular times. The patient discusses his problems and the therapist comments on them. This provides the patient with a learning opportunity to see both his abilities and his limitations more objectively, to view his major relations and his work in broader perspective, to see choices where he saw only one uncontrollable course of action previously, and to exercise the choices that will yield maximum benefit to him. In addition to talking, the patient *behaves* in the psychotherapy relation: he reenacts his characteristic roles, expectations, and self-defeating ("neurotic") or grossly distorting ("psychotic") styles of life. The therapist observes the non-verbal behavior and communicates verbal insights and emotional rèsponses that structure the therapeutic relation so that it exposes rather than gratifies or reinforces the patient's usual self-defeating roles and attitudes. From his learning in therapy, the patient can apply his new knowledge to the rest of his life.

Table 9 details timing and place of psychotherapy. All of the 14 patients seen three or more times a week were initially hospitalized. After discharge, only two required continuation of this frequency as outpatients. Most patients (77%) were seen as outpatients only.

Table 9

Timing and Place of Psychotherapy (No.=94)

Number of Psychotherapy Sessions	
3-10	19%
11-25	26%
26-50	12%
51-75	13%
76-100	12%
101+	18%
Duration in Months	
1- 2	22%
3- 6	28%
7-12	11%
13-18	17%
19-24	6%
25+	16%
Primary Frequency of Sessions	
Once every 2 weeks	6%
Once a week	57%
Twice a week	22%
3-5 times a week	15%
Place	
Outpatient only	77%
Inpatient and outpatient	16%
Inpatient only	7%

Table 10 lists the concomitant use of drugs with psychotherapy. The majority (58%) received no drugs; of these who did, all had discontinued them by the time psychotherapy terminated.

Outcome of Psychotherapy

These evaluations have been made by the author, based on what the patients said about themselves and also on the author's observation of what had occurred objectively in the patients' lives. Table 11 lists four criteria for measuring change in psychotherapy: symptoms, character organization, self-esteem, and psychosocial comfort.

Table 10

Use of Drugs with Psychotherapy (No.=94)	
None	58%
Minor Tranquilizers (Non-Phenothiazines)	10%
Major Tranquilizers (Phenothiazines)	16%
Antidepressants	16%
Alone (6%)	
With tranquilizers (10%)	

The relief of symptoms is the patient's primary motive for consulting the psychiatrist. By this criterion, psychotherapy was helpful: 72% improved moderately or markedly. Only 2 became worse: both were schizophrenics, a syndrome which occasionally has an inexorable decline.

Character organization may be defined in many ways. For purposes of reliable measurement,[8] it is defined as the individual's psychological traits and social roles which are acceptable and desirable to the self. This contrasts with symptoms, which are always perceived as alien and undesirable. Hence, the patient is much less motivated to change his character than to change his symptoms.

The following case history illustrates the contrast between character organization and symptoms. A 50 year old married male consulted me because he was suffering from symptoms of lack of energy, difficulty in his work, episodes of "nervousness," and spells of "feeling blue." I diagnosed his primary symptom area as a moderate depression and his secondary symptom area as somatic complaints. As he described his life, it became obvious that he rigidly organized all of it. He worked at his executive job "according to the book." He ran his home "like a tight ship:" he issued directives to his wife and daughter, posting them on the bulletin board each morning. He never relaxed or played; his spare time was spent in watching a little television and sleeping. The success of his occasional vacation was measured in how accurately he kept his traveling schedule and how detailed he recorded his expenses. These psychological traits and social roles supplied the basis for a character diagnosis of a compulsive personality trait disturbance. The patient wished to change only his symptoms which were distressing him; he admired his entire style of life, although it distressed his wife and daughter and caused him difficulty in his job.

Table 11

Outcome of Psychotherapy According to Specific Criteria (No.=94)

	Symptoms	Character Organization	Self-Esteem	Psychosocial Comfort
+3 Markedly Improved	33%	10%	20%	37%
+2 Moderately Improved	39%	20%	23%	21%
+1 Mildly Improved	15%	23%	27%	27%
0 No Change	11%	45%	25%	14%
−1 Mildly Worse	1%	2%	3%	0%
−2 Moderately Worse	1%	0%	2%	1%
−3 Markedly Worse	0%	0%	0%	0%
Percentage That Improved Markedly or Moderately	72%	30%	43%	58%

It soon became obvious to the patient and to me that his symptoms were the eventual payoff to a lifetime of rigidity. His adolescent daughter was currently rebelling against him and seeking to establish more freedom in her own life. This made him very angry, but he soon realized that he also envied it, as he had experienced the same conflict in his adolescence only to capitulate to his rigid parents and settle into his adult compulsivity. Within two months he became more flexible in his attitudes and behavior, with improvements in his relations both at home and in his job. At that point his symptoms disappeared; they had not returned three years later. He was rated as "markedly improved" in symptoms and "moderately improved" in character organization.

Self-esteem and psychosocial comfort are dimensions that have been found meaningful in measuring change in psychotherapy.[10] Self-esteem is how well or badly one thinks of oneself. Ninety-one per cent of these patients had a negative self-esteem prior to beginning psychotherapy. At the end, 59% had a positive self-esteem. Psychosocial comfort is the patient's estimate of his ease in social situations and relations. Whereas 97% were on the negative side prior to psychotherapy, 60% were on the positive side at the end of psychotherapy.

The overall outcome presented in Tables 12 and 13 is based on the results from Table 11. It has been computed as follows: the results for each of the four criteria were rank ordered, ranging from +3 for "markedly improved" through zero for "no change" to −3 for "markedly worse." The algebraic sum for these criteria yielded the following categories:

+9 to +12:	markedly improved
+5 to + 8:	moderately improved
+1 to + 4:	mildly improved
0 :	no change
−1 to − 4:	worse.

Table 12

Outcome of Psychotherapy According to Diagnosis

	Markedly Improved	Moderately Improved	Mildly Improved	No Change	Worse	Percentage That Improved Markedly or Moderately
Psychoneurotic Disorders (No.=30)	50%	43%	7%	0%	0%	93%
Personality Disorders (No.=42)	14%	24%	41%	21%	0%	38%
(Personality trait disturbance) (No.=23)	(26%)	(31%)	(31%)	(12%)	(0%)	(57%)
(Personality pattern disturbance) (No.=15)	(0%)	(13%)	(47%)	(40%)	(0%)	(13%)
(Sociopathic personality disturbance) (No.=4)	(0%)	(25%)	(75%)	(0%)	(0%)	(25%)
Schizophrenic Reactions (No.=22)	45%	27%	14%	0%	14%	72%
Total (No.=94)	33%	31%	23%	10%	3%	64%

Table 12 shows that the three diagnostic categories responded with "markedly improved" or "moderately improved" results in the following proportions: psychoneurotics, 93%; schizophrenics, 72%; and personality disorders, 38%. The relatively poor response of personality disorders is striking. There are several possible explanations. Most patients whose symptom problem areas were "lack of impulse control" and "disturbed interpersonal relations" (the two symptom problems areas least responsive—Table 13), occurred mainly in personality disorders. Another factor was rigidity: personality disorders are a "lifelong pattern" and are fixed and rigid by adulthood. The Standard Nomenclature states that the subtype, personality pattern disturbance, "can rarely if ever be altered . . . by any form of therapy."[6] This study indicates that although personality disorders do respond to psychotherapy, they are less responsive than psychoneurotics or schizophrenics.

Table 13 lists the outcome of psychotherapy according to symptom problem areas. The primary and secondary symptom problem areas (Table 7) were added together to produce the results. Somatic complaints were most responsive, a finding which should encourage physicians to consider psychiatric referral for those patients who have no organic lesion to account for their physical symptoms. Depression, confusion of self-identity, marital conflict, and sexual difficulties all responded with marked or moderate improvement for 65% of the patients.

The symptoms of lack of impulse control and disturbed interpersonal relations do less well. To participate in psychotherapy requires an ability to control one's impulses, to stop behaving erratically, and to consider one's behavior objectively. The habit of "acting out," such as the alcoholic continuing to drink, may be extremely difficult to curtail. If the patient has disturbed interpersonal relations, he will express that difficulty in psychotherapy. This hampers its effectiveness.

Three symptoms listed in Table 7—nonspecific dissatisfaction with life, difficulty with parents, and anxiety—are not included in Table 13 because the number of cases was too small to yield reliable results.

(Continued on page 202)

Table 13

Outcome of Psychotherapy According to Symptom Problem Areas (No.=94)

	Markedly Improved	Moderately Improved	Mildly Improved	No Change	Worse	Percentage That Improved Markedly or Moderately
Somatic Complaints (No.=15)	27%	53%	13%	7%	0%	80%
Depression (No.=34)	35%	38%	21%	6%	0%	73%
Confusion of Self-Identity (No.=34)	44%	26%	18%	6%	6%	70%
Marital Conflict (No.=34)	35%	29%	24%	6%	6%	64%
Sexual Difficulties (No.=17)	41%	24%	24%	11%	0%	65%
Lack of Impulse Control (No.=24)	17%	29%	42%	8%	4%	46%
Disturbed Interpersonal Relations (No.=14)	29%	14%	21%	36%	0%	43%
Total (No.=172)	34%	31%	23%	9%	3%	65%

THE VIEW BOX

By Leon Love, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School



This infant presented at birth with congenital cataracts and a murmur consistent with patent ductus arterosis.

WHAT'S YOUR DIAGNOSIS?

1. Congenital lues.
2. Hypophosphatasia.
3. Rubella syndrome in infants.

(Answer on page 210)

Medical Management Of Obese People: Timely Observations

By Frank L. Bigsby, M.D. and Cayetano Muniz, M.D./Chicago

The American Medical Association recently issued the following statement of policy:

"The practice of physicians concerned with weight reduction is a subject of increasing medical interest."

"There is no ethical nor legal ruling which would prevent a physician from limiting his practice to the treatment of obesity but this is not a recognized specialty. Since obesity may be only a sign, many disciplines of medicine may be involved in proper treatment."

"Any physician particularly concerned with the treatment of obesity should recognize that his practice and the care of patients should follow all professional and ethical rules governing the practice of medicine. A physician should not advertise his services; he should not exploit the patient in any way. The use of drugs must be carefully controlled by the physician."

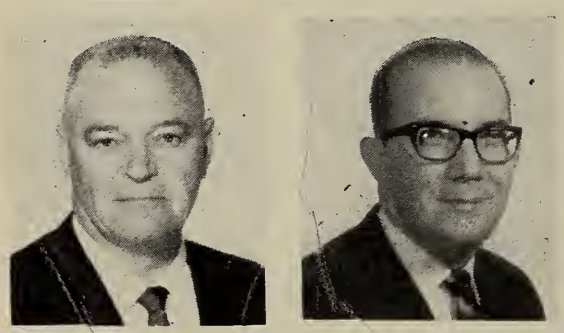
"The treatment of obesity cannot be isolated from concern for co-existing diseases such as diabetes and heart disease, and requires very definite diagnostic skills and close supervision of the patient. It is vitally important that physicians working in this area have a thorough knowledge of all aspects of internal medicine. The methods which a physician uses in this area should be based on all knowledge of human physiology and metabolism and on current information concerning the patient's responses to weight reduction. There are health hazards in weight reduction and these should be thoroughly understood and appreciated."

The statement is undoubtedly endorsed by every physician. It is hoped that the opinions voiced will result in positive action by concerned physicians and that the past tendency to treat *weight* rather than *people* will be reversed.

An important step in successfully treating *people* is the realization that the physician's prime goal is to initiate a long term dietary regimen and then *employ every ethical, truthful, and healthful means at his disposal to prevent the patient from prematurely breaking off the program.*

Clearly, the weapons at our disposal to promote long term dieting are inadequate. The naive attitude that the physician should merely admonish the patient to push away from the table and perhaps to increase energy expenditure is excellent advice for cooperative patients. Unfortunately, there are from 20 to 40 million people (the figures vary) unwilling or unable to do this. Is this attitude consistent with the statement of policy issued by the American Medical Association that, since obesity may be only a sign, many disciplines of medicine may be involved and that the treatment of obesity cannot be isolated from concern for coexisting diseases? Dysuria, frequency, urgency and tenesmus may be symptoms of acute cystitis. Should the physician advise this patient to go home and stop urinating?

Thousands of physicians having insufficient time to devote to the problem know that a pep talk with a calorie chart is inef-



Frank L. Bigsby, M.D., left, is a graduate of Tulane University School of Medicine, a general practitioner with special interest in clinical aspects of hyperphagia and disturbed nutrition. He served his internship at Kansas City General Hospital and a residency at Barnes Hospital, St. Louis. Cayetano Muniz, M.D., right, is a general practitioner with a special interest in weight disorders. He received his M.D. from the University of Havana School of Medicine, Cuba and served a residence in psychiatry at Middletown State Hospital, Middletown, N.Y.

fective so they supplement the chart with hastily scribbled prescriptions for diuretics and anorexiants, perhaps with a periodic injection of a mercurial. Is this practice consistent with the principles issued by the Medical Association?

The "fat doctor" currently in the headlines is guilty of drug abuse in treating *weight* rather than *people*. It is an accepted fact that the weakness of supportive medication in a dietary program is that there may be a total loss of effectiveness within a four to six week period. This is particularly true when the dietary program is offhandedly and briefly presented, when both physician and patient rely solely on medication for results. With early loss of drug effectiveness the only alternative is escalation of dosage to dangerous levels. This practice clearly flaunts every principle outlined in the AMA statement.

To effectively overcome the above shortcomings the physician should employ every acceptable method to keep the patient in a dieting frame of mind; the mood to diet must be sustained indefinitely (a good definition of motivation): this allows medication to support a regimen in a safe, healthful and controlled manner.

The only intelligent way to treat obese people is to treat the people and not their obesity. An attempt must be made to understand the patient. Clearly, prescribing a diet is ineffective unless motivation is sufficient to keep him on it indefinitely: improving motivation depends upon improving insight into the true nature of the problem. Improving insight is impossible without developing an excellent patient-doctor relationship.

How can rapport, insight, and motivation be improved? Surface or superficial psychotherapy is the one logical method that merits universal consideration. It contains four elements: 1) *aeration and ventilation*—encouraging the patient to talk freely about overweight and the problems it produces; 2) *explanatory therapy*—providing a judicious explanation of causes of overeating, refuting mistaken ideas about other phases of obesity; 3) *manipulative therapy*—prescribing a long term, prudent diet to produce gradual weight loss, a diet that can be maintained the many years that may be required to learn to say "no" permantly; 4) *supportive therapy* (a poor fourth in importance)—the intelligent and controlled use of medication.

Finally, the success of this program requires special knowledge, time, interest, and proper personnel. In this sense alone the management of obese people may someday be considered a medical specialty.

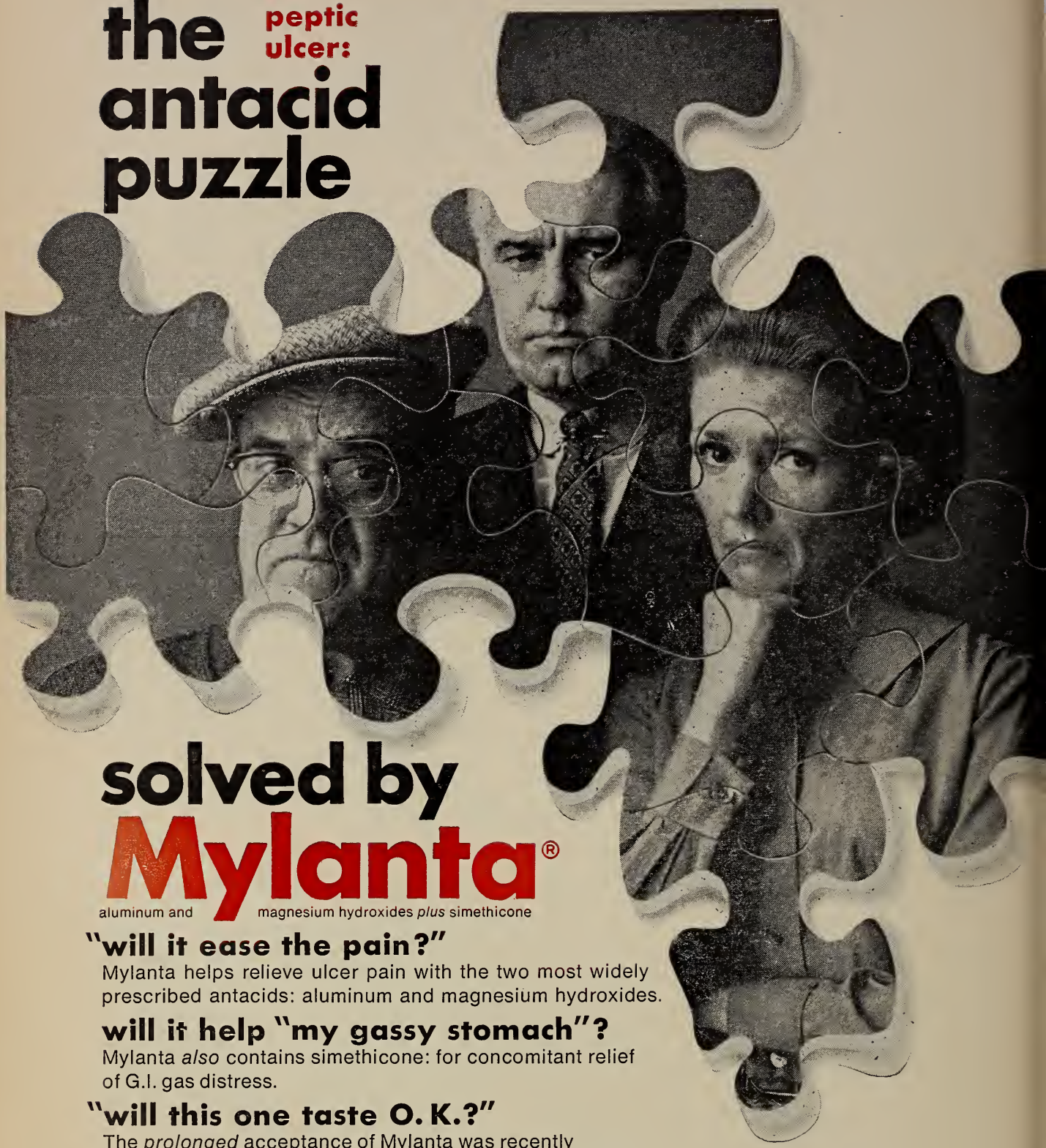
Internal Bleeding

The use of selective celiac and superior mesenteric arteriography in the diagnosis of acute gastrointestinal bleeding is a valuable diagnostic procedure. Because the diagnosis rests on demonstration of contrast medium outside the vascular bed, in the lumen of a hollow organ, it is mandatory that the patient be actively bleeding at the time of examination. Bleeding of 0.5 ml per minute can be demonstrated if the contrast medium is injected selectively into the appropriate visceral artery. In this small series of four patients arteriography accurately localized the site of bleeding. In actively bleeding patients, arteriography should precede barium studies because the barium in the intestine may obscure the extravasated contrast medium. Barium studies can follow arteriography immediately when the point of bleeding has not been identified.

Arteriography is most helpful in demonstrating arterial bleeding, but can also disclose venous abnormalities such as varices. Arteriography is also useful in chronic cases in which barium studies failed to localize the site and cause of bleeding. Lesions such as aneurysms of abdominal vessels, arteriovenous malformations, and traumatic ruptures of viscera may be best demonstrated by this method. (Angiographic Localization of Unknown Acute Gastrointestinal Bleeding Sites. Edward Mallinckrodt. Radiology (Aug.) 1967; 89:244-249.)

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Opinions and Reports on Ethical Relations

Payment of Physician for Services Performed by Intern Under His Direction or Supervision

The Council agreed that when a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction and supervision. (Judicial Council; Council on Medical Service, 1965)

Charging Penalty for Over-due Accounts

Since the practice of medicine is a profession and not a business, the practices adopted by businessess are not necessarily suitable.

It is not in the best interest of the public or the profession to charge a penalty if fees for professional services are not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection. (Judicial Council, 1962)

Bill for Respiratory Services Provided by Lay Organization

It is not ethical for a physician to bill a patient for respiratory services provided by a lay organization. A physician should limit his income to services he actually renders to the patient. A physician should not collect for services he does not render. (Judicial Council, 1962)

Rebates from Sale of Medicines or Appliances

It should be well known by this time that the traditional interpretation of the Principles of Medical Ethics by the various Judicial Councils in the history of the Association has been that the doctor may receive no profit whatever from his patient other than payment for rendered medical services. Hence it should be apparent that no rebate of any kind, in any form or from any source can be accepted. This applies also to rebates coming from agents or owners of optical companies. They are, in every case, absolutely unethical. (House of Delegates, 1947)

Rebates and Commissions

The acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical. (Principles of Medical Ethics, 1955 Edition, Chapter I, Section 9.)

Fee Splitting Defined

By the term secret splitting of fees is meant the sharing by two or more men in a fee which has been given by the patient supposedly as the reimbursement for the service of one man alone. By secrecy is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It includes those cases in which the term assistant is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed. The term commission refers to those rebates, "rake offs," or pro rata moneys sent for referring patients or favors received and not for medical and surgical services rendered.

The Judicial Council recommends for adoption by the House of Delegates the following resolutions:

Resolved, That any member of the American Medical Association found guilty of secret fee splitting or of giving or receiving commissions shall cease to be a member of the American Medical Association.

Resolved, That the House of Delegates of the American Medical Association recommends to each constituent body that it endeavor through the action of its various county societies to reform the various abuses of lodge practice in their separate communities in order that the lodges may give an adequate service to its members and an honorable remuneration to the medical men. (House of Delegates, 1912)

Fee Splitting is Giving or Receiving A Commission

The Judicial Council holds to the opinion that a division of a fee constitutes a giving and receiving of a commission. (House of Delegates, 1929)

SOCIO ECONOMIC news

A service of the Public Relations and Economics Division

Hospital Planning Proposal Stirs Debate in Illinois

A proposed statement of the American Hospital Association on areawide planning review has stirred controversy in Illinois. The proposal would commit hospitals to areawide health-planning agency approval as a condition for reimbursement of capital development costs. Backers argue that the Government otherwise would refuse to allot reimbursement funds, and would impose arbitrary controls on hospital expansions. Opponents contend that the planning agencies would not understand the unique needs of hospitals, and would hamper a hospital's private funding arrangements. The Assembly of the Illinois Hospital Association has expressed "reservations" to the AHA statement, which reportedly is being reworded. The ISMS Executive Committee has asked the society's Hospital Relations Committee to weigh the issue. A major debate is expected when the AHA House of Delegates meets next month in Atlantic City, N. J.

ISMS Malpractice Program Off To Flying Start

The ISMS-sponsored malpractice insurance program has started in high gear. More than 75 applications and 250 inquiries had been made by July 1, just a week after availability of the insurance was announced. The response was reported by Parker, Aleshire & Company, 9933 N. Lawler, Skokie, Ill., 60076, administrator. ISMS will directly supervise and control the program, in conjunction with the administrator and underwriter (Employers' Group of Insurance Companies, Boston). Coverage up to $1,000,000 is available, regardless of age or type of specialty. In an effort to discourage nuisance claims and stabilize premium rates, firm steps will be taken to improve the legal climate in the malpractice field. A Board of Trustees report at the AMA convention last June noted that malpractice insurance rates have risen 10 to 50 per cent in 20 states this year because of the rising incidence and size of claims.

ISMS Gets Many Appeals on Usual/ Customary Fees

Appeals representing some 500 physicians have been handled by the ISMS Committee on Usual and Customary Fees since its establishment two years ago. The complaints generally were that the Illinois Department of Public Aid had reduced or delayed fee payments. A physician having such a complaint can carry his appeal through the following steps: (1) to Robert G. Wessel, chief of the Division of Medical Administration, Illinois Department of Public Aid,

1035 West Outer Park Drive, Springfield; (2) to his county medical society if no understanding is reached with the IDPA headquarters; (3) to his ISMS district trustee or committee, and (4) to the ISMS Usual and Customary Fees Committee, which meets periodically with IDPA officials.

HEW Sets Regional Meet on Health-Care Costs

Leaders from the health community, insurance, labor and general public in five states, including Illinois, will take part in a Regional Conference on Health Care Costs Oct. 17 and 18 in Cleveland. The Department of Health, Education and Welfare is conducting such conferences to review various health-cost plans and stimulate interest at the local level. Attendance will be by invitation. The conference advisory committee includes Dr. Charles L. Hudson, Chicago, director of the AMA division of health services.

AMA Adopts Illinois Idea on Disaster Medical Care

An Illinois resolution on disaster medical care was adopted, with minor changes, at the AMA's San Francisco convention. It calls on Governors and other officials, both state and local, to plan adequate protection of medical personnel, hospital equipment and patients during civil disorders. "Medical personnel must be free to treat patients without interference and without fear of injury to patients, or damage to the facilities in which they work," the resolution states.

Illinois Below U. S. Average in Per Capita Public Aid

Illinois ranked below the national average last December in the percentage of population receiving money in the Assistance to the Aged, Blind or Disabled, Aid to Dependent Children and General Assistance programs. The newly released HEW figures listed Illinois as 24th among the 50 states, and sixth among the 10 most populous states—well below California and New York.

Hospital Costs Rise 15% in One Year

The average cost of a day's care in a U.S. general hospital was $58.06 last year—up 15 per cent from the year before. Salaries of hospital employees accounted for $36.30, or more than 62 per cent, of last year's daily expense bill. The figures, released by the Health Insurance Institute, were based on an AHA study of 656 hospitals. Overall, the nation's community hospitals spent $12.6 billion on payrolls, equipment, services, supplies and employee fringe benefits during 1967—up $2.1 billion from the year before.

By DON B. FREEMAN

Psycho-Social Aspects of Smoking

A clear cut smoker's personality has not emerged from the results so far published. While smokers differ from non-smokers in a variety of characteristics, none of the studies has shown a single variable which is found solely in one group and is completely absent in another. Nor has any single variable been verified in a sufficiently large proportion of smokers and in sufficiently few non-smokers to consider it an "essential" aspect of smoking.

The overwhelming evidence points to the conclusion that smoking—its beginning, habituation, and occasional discontinuation—is to a large extent psychologically and socially determined. This does not rule out physiological factors, especially in respect to habituation, nor the existence of predisposing constitutional or hereditary factors. (Smoking and Health.)

Do you have patients who try to hide anger behind charm?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns. 800321

Lilly Eli Lilly and Company, Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl® HCl
Nortriptyline Hydrochloride

(See last page for prescribing information.)

OBITUARIES

***Dr. C. M. Barr,** Percy, a veteran of 56 years of Illinois medical service, died June 9 at the age of 92. He was a member of the ISMS Fifty-Year Club.

***Dr. John Franklin Beyerle,** Kewanee, 72, died June 26. He was a member of Mohammed Shrine of Peoria, Kewanee Masonic Blue Lodge, Veterans of Foreign Wars, Henry County Medical Society and on the staffs of Kewanee Public and St. Francis Hospitals.

***Dr. Edward J. Clancy,** Santa Barbara, Calif., a practicing physician in Chicago for 27 years, died June 22 at the age of 55. He was battalion surgeon for the 1st Marine Division during the Guadalcanal Campaign in World War II.

***Dr. George A. Darmer,** an Aurora physician for more than 50 years, died June 12. He was a member of the American College of Surgeons, Academy of Ophthalmology and Otolaryngology, ISMS Fifty-Year Club and an emeritus member of the staffs of Copley Memorial and St. Joseph Mercy Hospitals.

Dr. Othello Ennis, Chicago, died July 2 at the age of 67. He was a member of the Provident Hospital medical staff.

***Dr. William I. Fishbein,** Lincolnwood, director of the Bureau of Health Services, the Chicago Board of Health, died May 30 at the age of 67.

***Dr. Robert L. French,** Oak Park, chief radiologist in Oak Park Hospital for 42 years, died June 14 at the age of 79.

***Dr. Garnett M. Frye,** Peoria, died May 27 at the age of 62. He was past president of St. Francis Hospital medical staff, Peoria Medical Society and on the boards of St. Francis, Methodist and Proctor Hospitals.

***Dr. Samuel L. Governale,** Chicago, 69, died in St. Bernard's Hospital where he had formerly been a staff member and chief of surgery.

Dr. Ewald E. Hermann, a physician and surgeon in Highland, died May 22 at the age of 73. He was a member of the International College of Surgeons, a former president of the Highland Chamber of Commerce and Madison County Medical Society.

***Dr. Holger N. Hoegh,** Chicago, died June 11 at the age of 70.

***Dr. William D. Jack,** 79, who practiced medicine in Chicago for more than 50 years, died July 2. He was governor and a trustee of Henrotin Hospital, a member of ISMS Fifty-Year Club.

***Dr. Glenn S. Nelson,** 67, a physician in the Chicago area for 40 years, died July 2.

***Dr. Alfred Nienow,** Argo, 79, a physician and surgeon in the Argo-Summit area for more than 40 years, died May 16.

***Dr. Irving B. Richter,** Chicago, 55, a pediatrician and faculty member of the University of Illinois Medical School, died June 24.

Dr. Albert J. Roemisch, Chicago, 83, a former Blue Island health commissioner for 38 years, and a police surgeon, died May 29.

***Dr. Donald T. Rolnick,** Hines, 40, a urologist, died June 24. He was on the staff at Michael Reese Hospital.

***Dr. Seymour R. Steinhorn,** Winnetka, a psychiatrist on the staff of Michael Reese Hospital, died May 31.

Dr. Anna Sorna VanPaing, La Grange, a physician and surgeon in the Chicago area for 46 years, died June 8 at the age of 88.

***Dr. Thomas F. P. Walsh,** Chicago, 80, died May 31 in Mercy Hospital where he was a 50 year staff member. He was also a member of ISMS Fifty-Year Club.

*Indicates membership in the Illinois State Medical Society.

Togetherness

Each characteristic and institution of suburban life testifies that the "lonely crowd" is everywhere. The suburbanite does not live in a house that expresses his individuality or blends landscape and architecture. Instead, he either builds a house that expresses the values of the real estate experts or settles in a large housing development of quarter-acre parcels. His house, as much like his neighbor's as possible, is crammed with mechanical conveniences that reflect a preoccupation with consumption. Arranged for entertainment, these houses are built to encourage family and neighborhood sociability. They are erected as symbols of material well-being and "togetherness," the new social ethic in practice. (Suburbia and Suburban Man, Carter, Robert M., GP (Mar.) 1968; 37:3;122-128.)

MEETING MEMOS

Aug. 31-Sept. 2—The Pulmonary Circulation, A Satellite Conference of the Congress of the International Union of Physiological Sciences. To be held in Chicago, the conference is sponsored by the Univ. of Chicago, Michael Reese Hospital, the Chicago Heart Ass'n., and the Tuberculosis Institute of Chicago and Cook Co. Reports of new medical research will be made by 22 medical scientists from six countries; in addition, 51 doctors from 16 countries will discuss these reports.

Sept. 7-11—The Second International Congress of the Transplantation Society will meet in New York City at the Americana Hotel. More than 2,000 members and guests from around the world are expected. The scientific program will feature, among other things, sessions on bone marrow transplantation, and cancer and pregnancy in their relationship to transplantation. A full day will be devoted to the transplantation of organs, including kidney, heart, liver, lung, and others. Body rejection will be covered at length.

Sept. 9-11—San Francisco is the site of the Continuation Course in Clinical Electroencephalography. It is a basic review of the applications of EEG to clinical medical practice. Inquiries about the course should be directed to Dr. Klass, EEG Course Director, Mayo Clinic, Rochester, Minn. 55901.

Sept. 9-13—The Third International Congress of Phlebology is scheduled to be held in Amsterdam, the Netherlands. The congress is held in conjunction with the International Society of Lymphology. The venous system of the lower limb, congenital abnormalities of the venous and lymphatic systems, and varicose conditions of the lower limb are the main subjects to be covered. Round table conferences on pertinent therapeutic problems are planned.

Sept. 16-20—The Cook County Graduate School of Medicine is sponsoring the Fifth Sumner L. Koch Hand Surgical Symposium. The Department of Surgery of Northwestern University Medical School is also sponsoring this. "Reconstruction of the Injured Hand" will be the theme of the main address.

Sept. 20-27—To be held in New York City, at the Hilton Hotel, the 9th International Congress of Neurology and the 4th International Congress of Neurological Surgery will meet jointly as the World Congresses of Neurological Sciences. Attendees from 40 countries are expected. Scientific sessions for each group as well as joint sessions are scheduled. Several related groups will hold meetings at the same time: the Fulton Society, the International League Against Epilepsy, the International Multiple Sclerosis Society, the International Society for Research in Stereoencephalotomy. Major themes for the meetings are epilepsy and cerebral vascular disease.

Sept. 23-Oct. 4—The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the University of Illinois College of Medicine will conduct a postgraduate course in Laryngology and Bronchoesophagology. Attendance is limited to 15. It will be held at the Infirmary. There are to be demonstrations, practice in bronchoscopy, diagnostic and surgical clinics, and didactic lectures.

Sept. 26-28—The Skirvin Hotel, Oklahoma City, is the meeting site for the Central Association of Obstetricians and Gynecologists.

CBS To Acquire W. B. Saunders Company

Columbia Broadcasting System, Inc., and W. B. Saunders Company have agreed on terms by which CBS will acquire the assets and business of the medical publishing firm. The announcement was made by William S. Paley, CBS chairman, and Frank Stanton, president, and by Lawrence Saunders, W. B. Saunders Company chairman, and Harry R. Most, president.

Organized in 1888, W. B. Saunders Company is a leading publisher in the medical field, with headquarters in Philadelphia. It will operate as a division of the CBS/Holt Group, whose president is Alfred C. Edwards. In addition to publishing books and magazines for the general reader, the Group develops and distributes educational materials and systems for schools and colleges in this country and abroad.



"Will I ever catch up on my work?"

Mebaral® usually calms the anxious patient without the degree of languor, or decrease in alertness often caused by other barbiturates.[1] Mebaral is particularly valuable in treating anxiety-tension states *when minimal hypnotic action is desired.*[2] Its sedative action is prolonged[3] and predictable.

Contraindication: Large doses are contraindicated in patients with nephritis.

Warning: May be habit forming.

Precautions: As with other barbiturates, caution is advisable during use in debilitated and senile patients and in patients with pulmonary disease.

Adverse reactions: Although Mebaral is generally well tolerated over long periods, the possibility of idiosyncrasy to barbiturates (as manifested by drowsiness, vertigo, and cutaneous eruptions) should be considered.

Dosage: *Adults,* for daytime sedation—½ gr. (32 mg.), ¾ gr. (50 mg.) and, at times, 1½ gr. (100 mg.), three or four times daily.

References: 1. Musser, Ruth D., and Shubkagel, Betty L.: Pharmacology and Therapeutics, ed. 3, New York, Macmillan Company, 1965, p. 363. 2. Council on Drugs, American Medical Association: New Drugs 1965, Chicago, American Medical Association, 1965, p. 157. 3. Modell, Walter (Ed.): Drugs In Current Use 1966, New York, Springer Publishing Company, 1966, p. 77.

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Winthrop

Mebaral® tablets:
32 mg. .....(½ grain)
50 mg. .....(¾ grain)
100 mg. .....(1½ grains)

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DEPENDABLE DAYTIME SEDATION



ILLINOIS ASSOCIATION OF THE PROFESSIONS

IAP was organized to . . . . .

". . . provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare.

". . . strengthen the traditional rights, privileges, and responsibilities of each profession.

". . . devise ways and means of better utilizing the professional knowledge and skills of its members for the benefit of society and attempt to create the kind of relations between the professions which will most effectively accomplish this objective.

". . . serve its members as one practical medium of communication between the professions and legislative bodies.

". . . supplement efforts, programs and services of the individual state professional societies.

". . . benefit the individual member by helping him protect and perpetuate the individual privileges and responsibilities of the professional person.

". . . serve as a medium of communication between the professions."

Opposes Laymen on Professional Boards

The Michigan Association of the Professions has strongly opposed packing of professional boards with laymen. A series of bills have been introduced in the Michigan legislature permitting a lay person to serve on the licensing and regulation boards of the several professions.

In opposition to this legislation, MAP stated "How could a layman be expected to understand such responsibilities and their relative importance unless he had been intimately involved by having himself practiced the profession.

The difference between a trade and a profession is that the trader frankly carries on his business primarily for the sake of pecuniary gain, while the members of a profession profess an art, their skill in which they place at the public service for a remuneration, adequate or inadequate, but which is truly an end in itself.

Annual Meeting of IAP

The fifth annual meeting of the Illinois Association of the Professions is scheduled for October 10-11, 1968 at the Ambassador Hotel in Chicago. Under the chairmanship of Marvin Mindes, J.D., the Annual Meeting Committee is planning an outstanding professional meeting.

The registration form will be mailed to the entire membership of the eight professions holding membership in IAP. This announcement in early September will include the complete program.

Illinois Water Resources

The report "Water for Illinois—A Plan for Action" is largely the result of studies made by professional engineers who have long advised public policy makers that the technology is available to control air and water pollution and provide adequate water supplies and recreation development if the funds are provided.

The billion dollar bond issue to be submitted to the voters of Illinois involves a twelve year action program and is supported by the ISPE who is encouraging its membership to explain and discuss the issue with voters in their communities.

That's why Abbott offers you a pill plus a program.

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The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

Please see Brief Summary on next page.

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Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Environmental Pollution Due To Insecticides

Insecticides on our food or in the air may enter man and cause many prescribed drugs to be ineffective or even harmful. A great many such modern hazards face us in our increasing exposure to pollution of the environment by radiation, chemical agents, and pesticides.

For more than 20 years, the University of Chicago Toxicity Laboratory has devoted itself exclusively to research in locating, exposing, and controlling modern environmental poisons. Operating with a 20 to 25 man staff, it has made a number of important and often unnerving discoveries.

One such discovery was that insecticides, aerosol solvents, and perhaps many other environmental elements taken into the body from the air, by contact with skin, or by mouth can stimulate the liver to produce abnormally high levels of certain enzymes. "These enzymes," said Dr. Kenneth DuBois, Director, "cause increased detoxification of drugs, which may render the drugs therapeutically ineffective at the dosage levels that are normally used."

Tests in the Toxicity Laboratory have demonstrated conclusively, for example, that the effects of the frequently used sedatives such as the barbiturates are counteracted by DDT. "Such a counteraction has generally been written off by physicians as a natural resistance in the patient to the drug being used," he said.

If the physician knew that such a reaction is taking place as a result of stimulation of detoxification by environmental chemicals, he could increase the dose of the sedative and thereby obtain effective treatment, Dr. DuBois said.

DDT and other persistent pesticides pose some special problems. These problems have recently been acknowledged by the government's lowering of the allowable level of DDT in food.

The problem, according to Dr. DuBois, centers around the need for insecticides to maintain high agricultural production, but pesticide residues in the atmosphere and the soil are constantly rising.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

EDWARDS COUNTY: Albion; population: 2,000 and 10,000 in trade area. Urgent need for a second physician. Only physician is age 56. Nearest hospitals at Fairfield and Mt. Carmel, 16 and 18 miles. Evansville, Ind. 50 miles. One prescription drug store. Twelve protestant churches, grade and high schools. Agricultural community. For further information contact: Huldah M. Orr, Secretary, Edwards County Health Improvement Association, Albion. Phone: 618-445-2905.

EFFINGHAM COUNTY: Beecher City; population: 500. Community without a physician for 5 years, when only physician retired. Nearest at Effingham, 15 miles, and Cowden, six miles. Nearest hospital 15 miles. Decatur 60 miles. No drug store at this time. Community will provide a building for a physician or loan money. Three protestant churches, grade and high schools. Adequate recreational facilities. Active Masonic Lodge. For further information contact: Rev. S. Burkett Milner, Box 355, Beecher City. Phone: 618-487-4241.

FAYETTE COUNTY: St. Peter; population: 400. Trade area, 2,000. Located on state route 185. Town without a resident physician for many years. Nearest at Farina, six miles and Vandalia, 18 miles. Nearest hospital at Vandalia, 103 beds. Chicago and Eastern Illinois Railroad. Office and housing will be provided by Business Men's Association in accordance with doctor's wishes. Financial assistance. Agricultural community. Evangelical Lutheran Church. Public and parochial schools. Bus to high school, six miles. New sewer system. For further information contact:

O. J. Gluesenkamp, St. Peter

A. D. Hotz, St. Peter

FAYETTE COUNTY: Vandalia; population: 5,500. Opening in Moore Clinic; 2 GPs, need for a third. Ultra-modern 103 bed hospital. New high school and new swimming pool. Several industries. Located on Kaskaskia River, 60 miles from St. Louis. County seat of Fayette County; population: 28,000. New clinic building, 3 blocks from hospital. Three consultation rooms, ten examining rooms, office, receptionist office, waiting rooms. Large parking lot. For details contact:

S. W. Moore, M.D.

D. H. Rames, M.D., Vandalia

Phone: 283-0945 or 283-1209

FORD COUNTY: Melvin; population: 550. Trade area, 3,000. Town without a physician since 1961. Nearest hospital at Gibson City, 11 miles; 35 miles from Champaign. Office of former physician available if desired. Agricultural community. Churches: Catholic, Lutheran, Methodist. Grade and high schools. Active Lions Club, Masonic Lodge, VFW, American Legion, etc. Country club with golf and swimming facilities. Contact the President, Melvin State Bank, the Administrator, Gibson City Community Hospital, the Superintendent of Schools, or James Arnold, President, Melvin Lions Club.

FORD COUNTY: Paxton; population: 5,000. Four physicians, ages 86, 59, 47, and 32. Last three associated in Paxton Clinic, established in 1947. If new physician establishes solo practice, a GP is preferable; if he prefers to associate with Clinic, surgeon or obstetrician would be acceptable, if willing to do some GP. No investment necessary at first; opportunity for partnership after one year. Fully accredited 40 bed hospital. Thirty miles from Champaign. Three prescription drug stores. Churches: Protestant, Catholic. Grade and high schools. Local country club with golf and swimming. Contact: S. B. Furby, M.D., or Gene Noble, M.D. at 217-379-2361.

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DEPR



At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves... mood fluctuations lessen... sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type...any degree of severity.

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IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, dizziness, palpitation, delayed urination, agitation and stimulation ("jumpiness," "nervousness," "anxiety," "insomnia") bad taste, sensory illusion, tinnitus, sweating, drowsiness, headache, hypotension (orthostatic), flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy (general), altered liver function, ataxia and extrapyramidal signs, agranulocytosis.

Additional side effects more recently reported include: seizures, eosinophilia, confusional states with hallucinations, purpura, photosensitivity, galactorrhea, gynecomastia, and impotence. Side effects which could occur (analogy to related drugs) include weight gain, heartburn, anorexia, and hand and arm paresthesias.

DOSAGE: Optimal results are obtained at a dosage of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1,000; and tablets of 50 mg. in bottles of 30, 250, and 1,000.

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See package insert for complete prescribing information.

IHA Explains Emergency Service Rules to Member Hospitals

The current publicity about hospital emergency services has stimulated many questions about what is and what is not legally acceptable practice on "house staff" coverage. The Illinois Department of Registration and Education advises that they are now getting many such questions from hospitals across the state. The following, which has been cleared with the Department of R&E, the IHA legal counsel, and other authoritative sources, is an attempt to answer some of these questions.

ECFMG Certification. The Educational Council for Foreign Medical Graduates certification does not qualify anyone to practice medicine in Illinois. ECFMG is no more or no less than a voluntary screening mechanism for graduates of foreign medical schools, aliens or native born Americans, who wish to continue their medical education in the United States. (Class A Canadian Medical Schools and their graduates are treated as American.) As such, it provides a very useful service to teaching institutions considering applicants for residencies. In large part, this is why it was established. Physicians may enter the United States without ECFMG certification, and those with this certification need not function in a medical setting after their arrival. The ECFMG certification has no legal status as a consideration for issuing a temporary certificate of registration in Illinois.

Temporary Certificates of Registration. The only persons authorized to practice medicine in Illinois are holders of a full license or temporary certificates of registration. The authorization to practice medicine with a temporary certificate is on a very clearly defined and delimited basis. To receive such a certificate the applicant must establish that he is accepted for residency of specialty training in an Illinois hospital approved for this purpose by the Department of R&E. (NOTE: These approvals coincide with the AMA-approved list). He receives such a certificate for one year only, though it is subject to renewal. Though the certificate is issued to the physician by name, it must be kept in the care and custody of the hospital. The hospital is required to return the certificate to R&E when the physician completes his training period or leaves for some other reason. The Department of R&E is explicit on the point that the certificate is only valid for the hospital which accepted the physician for residency training. Without another approval process, he is not authorized to practice medicine in any other setting.

Employment of holders of ECFMG and/or temporary certificates. There is no law against a hospital employing a physician who has no more than an ECFMG certification or has been issued a temporary certificate or registration at another hospital. The only prohibition is against employing and using him as a physician or presenting him to the public as such. According to Frank R. Petrone, Chief, Technical Advisor of the Department of R&E, "These individuals can't do anything more in the patient care setting than any other unlicensed person can do." Such a person can be employed as an "orderly" or as a "technician" but, as a protection to the hospital and the public, there must be clear understandings with the physician himself and by the hospital's medical staff that he must function in the hospital under medical supervision. This means, among other things, that he cannot independently perform any diagnosis or institute any course of treatment. In 1964, Mr. Petrone issued interpretations under the Medical Practice Act stating that unauthorized practice of medicine in these situations is a criminal offense by the individual involved. The hospital administrator or chief of staff who assigns such individual to illegal medical practice also may subject himself to the criminal offense of aiding or abetting the unlicensed practice of medicine.

Emergency Room Statute. Under state law (Chapter III-½, Sec. 86, Ill. Rev. Stat.) no general hospital can refuse to give emergency medical treatment to an applicant "in case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness."

There is no requirement that these cases be admitted as inpatients nor is there any prohibition against referring them to another institution. However, the judgment about the patient's condition is necessarily a medical one, and in Illinois only licensed physicians are qualified to make these judgments. We repeat a statement made by our IHA legal counsel, Harry L. Kinser, four years ago (IHA Document, "Hospital Emergency Service Under Illinois Law," May 19, 1964):

> "My conclusion is that an Illinois hospital must furnish emergency room service; that the governing board must provide how this is to be done and must adopt a system which will make a physician at all times available; that a member of the medical staff must comply with such requirements or incur the risk of losing his staff privileges and facing a charge that would jeopardize his status as a licensed physician."

Medical Licensure Verification. In the IHA document cited above, we recommended that every hospital arrange for routine verification of current licensure of every physician practicing medicine at that hospital including residents and out-of-state physicians who occasionally admit patients or provide professional consultation.

This may be done easily at the time staff privileges are annually reviewed. The Department of R&E advises us that they are always prepared, by letter or by telephone, to verify a given license number. The Department tells us that it plans soon to do another survey under which hospitals are asked to report the licensure numbers of all physicians on their staffs. We suggest that this is an appropriate time for hospitals to become current on this information.

NOTE: The Medical Practice Act, including Rule VIII (Temporary Certificates of Registration) and Rule IX (Limited License to Practice in State Hospitals) appears on page 551 of the October, 1967, issue of the *Illinois Medical Journal,* the annual reference issue.

New Cellular Component Found in Red Blood Formation

Scientists at The University of Chicago have found a new cellular component that arises during the process of red blood cell formation.

The component was found by Martin Gross, a graduate student, and Eugene Goldwasser, Professor of Biochemistry. Their work was done in The Argonne Cancer Research Hospital, which is operated by the University for the U.S. Atomic Energy Commission.

The new component was described in a paper Gross delivered at the 52nd annual meeting of the Federation of American Societies for Experimental Biology. It is a very large RNA that is formed as a result of the action of the hormone, erythropoietin, on the cells from which mature red blood cells are derived. Erythropoietin, which is produced mainly in the kidneys, appears to be the primary factor for triggering the conversion of the primitive cells in marrow to red blood cells.

The large RNA formed as a result of erythropoietin action is many times larger than any other RNA occurring in normal animal cells. It is present in such minute amounts that it can be detected only by using radioactive tracers to tag it when it is formed.

A recent refinement of method showed Gross and Goldwasser that earlier techniques had been causing the breakdown of these large RNA molecules, making them appear much simpler than they are. The function of this "monster" RNA has not yet been established, but finding it has forced these investigators to re-examine their concepts concerning the biochemical mechanisms underlying cellular differentiation.

"We now realize," Goldwasser said, "that the process of converting unspecialized cells to specialized ones involves switching on the sythesis of a large variety of new RNA types. This realization is forcing on us a need for new concepts in this field."

Such detailed information on how red blood cells are formed might lead ultimately to an understanding of the chemical process by which primitive cells are converted to cells with specialized function.

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Niacinamide	30 mg
Folic Acid	0.05 mg
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Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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Urban Private Psychiatric Practice

(Continued from page 178)

SUMMARY

The results with all 157 patients seen in a general psychiatric private practice in an urban area during a four year period (1960-1964) are reviewed. The "average" patient was 35 years old, middle or upper-middle class, overtly depressed as well as anxious, with multiple symptoms that disrupted all major areas of his life. Psychotherapy consisted of a median of 35 sessions over a median period of six months. The majority (58%) received no drugs. Overall results were: markedly improved, 33%; moderately improved, 31%; mildly improved, 23%; no change, 10% and worse, 3%.

Psychoneurotics and schizophrenics did best; personality disorders did worst. The most responsive symptom areas were somatic complaints, depression, confusion of self-identity, martial discord, and sexual difficulties, in that descending order.

References

1. Bahn, Anita K.: Conwell, Margaret; and Hurley, Peter: Survey of Private Psychiatric Practice, *Arch. Gen. Psychiat.* 12:295-302 (March) 1965.
2. Lockman, Robert F.: Nationwide Study Yields Profile of Psychiatrists, Article in *Psychiatric News* (January) 1966.
3. Hollingshead, August B., and Redlich, Fritz C.: Social Class and Mental Illness, New York: John Wiley and Sons, 1958.
4. Matarazzo, Joseph D.: Psychotherapeutic Processes, *An. Rev. Psychol.* 16:181-224, 1965.
5. Schofield, William. Psychotherapy: the Purchase of Friendship, Englewood Cliffs, N.J.: Prentice-Hall, 1964.
6. Committee on Nomenclature and Statistics of the American Psychiatric Association: *Diagnostic and Statistical Manual. Mental Disorders,* Washington, D.C.: American Psychiatric Association, 1952.
7. Hamburg, David; Sabshin, Melvin A.; Board, Frank A.; and Grinker, Roy R.: Classification and Rating of Emotional Experiences, *AMA Arch. Neur. Psychiat.* 79:415-426 (April) 1958.
8. Luborsky, Lester: Clinicians' Judgment of Mental Health, *Arch. Gen. Psychiat.* 7:407-417 (December) 1962.
9. Grinker, Roy R.; Miller, Julian; Sabshin, Melvin; Nunn, Robert; and Nunnally, Jum C.; The Phenomena of Depressions, New York; Hoeber Medical Division, 1961.
10. Frank, Jerome: Persuasion and Healing. A Comparative Study of Psychotherapy, Baltimore: The Johns Hopkins Press, 1961.

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USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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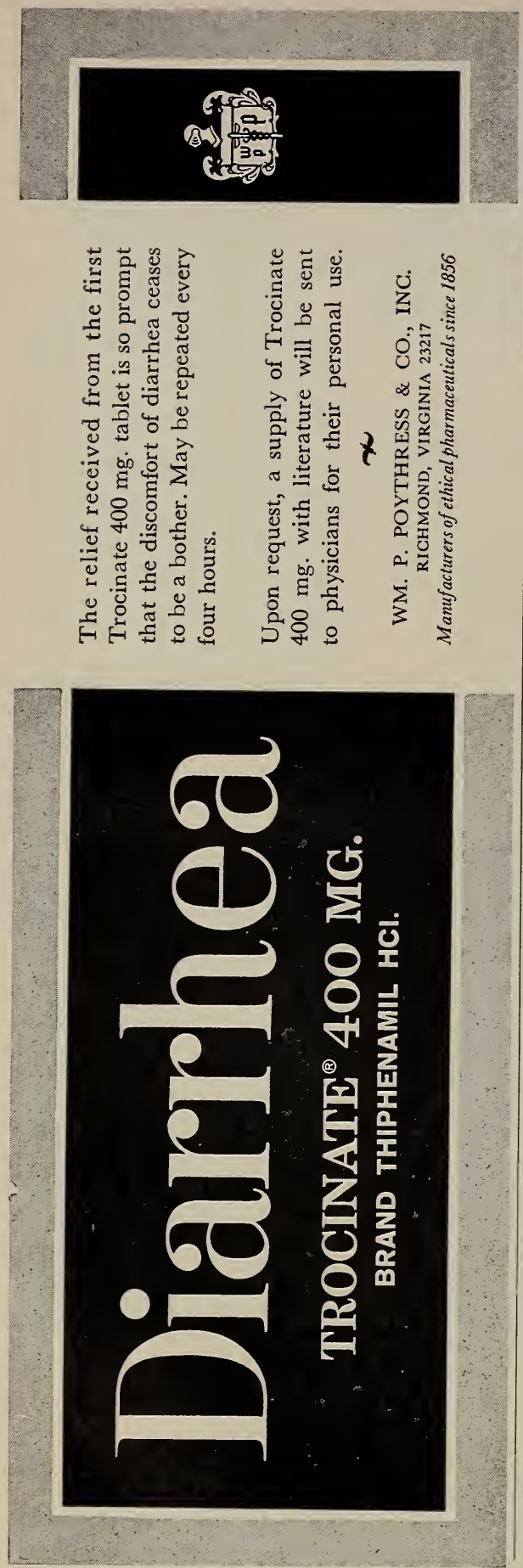


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Subdural Hematomas in Infants and Children

(Continued from page 170)

References

1. Christensen, E., and Husby, J.: Chronic Subdural Hematoma in Infancy. Acta. Neurol. Scand. 39:223-342, 1963.
2. Dowman, C. E., and Kahn, E.A.: Subdural Hematoma in Infants. South. Surg. 11:164-172, 1942.
3. Ford, F.R.: Diseases of the Nervous System in Infancy, Childhood and Adolescence. C.C. Thomas. 1960.
4. Gardner, W.J.: Traumatic Subdural Hematoma with Particular Reference to the Latent Interval. Arch. Neurol. Psychiat. 27:847-858, 1932.
5. Greenfield, J.G., and Russell, D.S.: Traumatic Lesions of the Central and Peripheral Nervous System. Chapter 7 in Greenfield's Neuropathology. The Williams and Wilkins Co. Baltimore, 1963.
6. Hendrick, E.B., Harwood-Hash, D.C.F., and Hudson, A.R.: Head Injury in Children. Clinical Neurosurg. Vol. 11, Baltimore. The Williams and Wilkins Co., 1964.
7. Ingraham, F.D., and Heyl, H.L.: Subdural Hematoma in Infancy and Childhood. J.A.M.A. 112:198-204, 1939.
8. Ingraham, F.D. and Matson, D.D.: Neurosurgery of Infancy and Childhood, Springfield, C.C. Thomas. 1961.
9. Lanzara, G., and Delgaudio, A.:Il Traumatismi Cranio-Cerebrali Nell Infanzia, Minerva Chir. 30:260-275, 1964.
10. McKissock, W., Richardson, A., and Bloom, W.H.: Subdural Hematoma. Lancet. 1:1365-1369, 1960.
11. Pia, H.W.: Die Traumatichen Hirblutingen des Kindersalter. Acta Neurochir. 11:583-600, 1964.
12. Putnam, T.J., and Cushing, H.: Chronic Subdural Hematoma—Its Pathology, its Relation to Pachymeningitis Hemorrhagica and its Surgical Treatment. Arch. Surg. 11:329-393, 1925.
13. Shulman, K., and Ransahoff, J.: Subdural Hematoma in Children. The Fate of Children with Retained Membranes. J. Neurosurg. 18:175-181, 1961.
14. Svien, H.J., and Gelety, J.E.: On the Surgical Management of Encapsulate Subdural Hematoma. J. Neurosurg. 21:172-177, 1964.
15. Tondury, G.D.: Das Subdurale Hamatom und Hygrom in Kindesalter. Schweiz. Arch Neurol. Neurochir. Psychiat. 99:299-312, 1967.

This study was supported by a grant from the Spastic Paralysis Research Foundation.

"Health on Wheels," a 14-minute black and white film depicts the basic principles applied in mobile multi-phasic chronic disease screening. Screening techniques, types of educational approaches, reporting systems and follow-up are all demonstrated. It has recently been released through the International Film Bureau, 332 S. Michigan Ave., Chicago, 60604. Purchase and rental inquiries may be addressed to the Bureau.

Abstracts of Board Actions

(Continued from page 138)

CONSIDERATION GIVEN TO SERVICES TO IDPA RECIPIENTS

The Advisory Committee to IDPA report involved a decision relative to telephoning a pharmacy or other vendor to prescribe or order medications, medical supplies or sick room needs for a public aid recipient; also, the situation relative to podiatrists participating in the care of public aid recipients was discussed. The Department of Public Aid was asked to seek the scientific advice of physicians and the legal advice of attorneys familiar with the Podiatry Act and the Medical Practice Act before proceeding further with the implementation of the law requiring IDPA to pay podiatrists directly for their services without prior referral by a physician.

MEDICAL SERVICE FOR CONVENTION

By official action, the chairman of the Board was authorized to offer to man a first aid station in cooperation with Chicago Medical Society (including ambulance and hospital facilities) for the Democratic Convention to be held in Chicago in August. An offer was to be made to the Democrat National Committee and if the idea was acceptable and practical, it would be developed.

MATERNAL AND PERINATAL MORTALITY STUDY

Dr. Stewart Abel appeared before the Board to discuss the Maternal and Perinatal Mortality Study. In 1964 Dr. Edward Dorr (deceased) was interested in the problem of standardizing records of maternal perinatal deaths throughout the country. The original committee in Illinois, where a pilot study was made, included Dr. Abel and Dr. Dorr, Dr. Robert Hartman, and Dr. Philipsborn, who was chairman of the ISMS Committee on Perinatal Mortality (no longer in existance). Since private funds were not available for the original study, the project lay dormant for the past three years. Dr. Abel asked that the entire project be revived, and the study be done in Illinois so that one state would have considered the problem on a "trial basis."

LISTING OF BOARD ACTIVITIES

By official action the Board was asked to set up a priority list of activities, using as a source for information on which to base such actions a committee composed of past presidents of the society. This group, through the Executive Committee, would make interim reports at least every six months.

CONSTITUTIONAL CONVENTION SUPPORTED

The Board approved support for the calling of a Constitutional Convention which will appear on the November ballot, and so recommended to the House of Delegates, which concurred.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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WILLIAM H. RORER, INC.
Fort Washington, Pa.

Practice of Medicine

(Continued from page 118)

cate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(Section 24 *Medical Practice Act.* [Chp. 91,, Sec. 16i, *1967 Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which

(Continued on page 212)

Clinics for Crippled Children

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. This includes twenty-one general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 4 Rock Island Cerebral Palsy —Foundation for Crippled Children & Adults, 3808 Eighth Avenue

September 4 Carmi—Carmi Township Hospital

September 4 Jacksonville—Holy Cross Hospital

September 4 Hinsdale—Hinsdale Sanitarium

September 5 Sterling—Community General Hospital

September 5 Effingham General—St. Anthony Memorial Hospital

September 5 Peoria Cerebral Palsy (a.m.) —Zeller Zone Center

September 10 East St. Louis—Christian Welfare Hospital

September 10 Peoria General—Children's Hospital

September 11 Champaign-Urbana—McKinley Hospital

September 11 Joliet—St. Joseph's Hospital

September 12 Macomb—McDonough District Hospital

September 12 Anna—First Christian Church

September 12 Springfield General—St. John's Hospital

September 13 Chicago Heights Cardiac—St. James Hospital

September 17 Alton General—Alton Memorial Hospital

September 18 Evergreen Park—Little Company of Mary Hospital

September 19 Decatur—Decatur & Macon Co. Hospital

September 19 Rockford—Rockford Memorial Hospital

September 19 Sparta—First Baptist Church Educational Building

September 19 Elmhurst Cardiac—Memorial Hospital of DuPage County

September 24 Belleville—St. Elizabeth's Hospital

September 24 Peoria General—Children's Hospital

September 25 Centralia—St. Mary's Hospital

September 25 Springfield Cerebral Palsy (p.m.)—Diocesan Center

September 25 Elgin—Sherman Hospital

September 26 Effiingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

September 27 Chicago Heights Cardiac—St. James

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

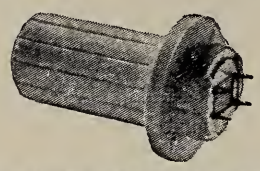
Vascular Changes in Arthritis

The synovial overgrowth produces the destructive changes of rheumatoid arthritis in the digits and is the predominant factor in the condition. Occlusive digital artery disease predominates in rheumatoid arthritis and starts in the digital arteries of the extremities. Vasculitis accounts for some of the polyneuropathy in rheumatoid arthritis and probably all of the demineralization. It is hoped that more interest will be shown in the vascular changes in arthritic conditions. (Radiographic Changes in Rheumatoid Arthritis in the Digits, T. R. Marshall, Radiology, (Jan.) 1968, 90:121-123.)

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Frank J. Jirka, M.D., Chairman
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(AC 312) 372-3437

Approve New Curriculum in Medical Dietetics

The University of Illinois Board of Trustees has approved authorization of the establishment of a curriculum in Medical Dietetics within the School of Associated Medical Sciences at the University's Medical Center Campus in Chicago.

The proposed curriculum, which would lead to the degree of Bachelor of Science in Medical Dietetics, must now be approved by action of the Illinois State Board of Higher Education. The curriculum had been endorsed by Dr. Joseph S. Begando, Chancellor for the Medical Center Campus, the Medical Center Campus Faculty Senate and University Executive Vice President and Provost Lyle H. Lanier.

According to a University spokesman the proposed program, which emphasizes the biological and physical sciences and the application of nutritional principles, represents a relatively new approach to the field of dietetics.

In addition to incorporating the latest developments in nutritional science, the program would integrate the classroom instruction with immediate practical application to patient needs.

The entire curriculum, it was emphasized, is based on detailed studies which indicate that the number of dieticians expected to be available by 1970 will be far below projected needs These studies also point up the need in hospitals for professional specialists in the field of applied nutrition.

Minimum requirements for admission are 60 semester or 90 quarter hours, at least a 3.0 (C) average and certain prerequisite courses. Requirements for graduation with the B.S. degree in Medical Dietetics include general education sequences in the biological, physical and social sciences and in the humanities.

* * *

Widows of veterans of all wars on the pension rolls of the Veterans Administration, who are blind or helpless enough to require regular aid and attendance, or who are patients in nursing homes, are entitled to receive $50 a month more than their regular pension payment.

Describe Insertion of Balloon in Heart to Aid Cardiac Victims

A balloon inserted into the heart to help victims of heart failure was described recently, at the University of Chicago.

The device was one of several mechanical assistances to the heart discussed by Dr. James R. Jude, head of the Division of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine.

At a conference on aggressive management of coronary artery disease sponsored by The University of Chicago School of Medicine and The American College of Cardiology, Dr. Jude described the process of inserting and using the balloon.

A double-passage catheter, or tube, with the deflated balloon attached is inserted in a patient with a failing heart through an incision in the groin, he said. It is then manipulated into the heart. At regulated intervals coinciding with the beat of the heart, the balloon is allowed to contract or expand. It is filled with helium or nitrogen to displace blood so the weakened heart can function on reduced pressure.

The balloon has been used up to 24 hours in a single heart attack victim by Dr. Adrian Kantrowitz in New York, said Dr. Jude.

He added that there might be some value in using such a method periodically to relieve the pressure on a victim of heart failure.

Dr. Jude also described a variation on the pacemaker which has been used successfully. Pacemakers are devices implanted by surgery into the body with electrodes attached to the heart wall. The pacemaker provides periodic electrical shocks that keep a weak heart beating regularly.

Since many people with heart problems require this stimulation but do not require it constantly, the newer pacemaker has a switch which permits the user to turn it on and off.

Such a unit, according to Dr. Jude, also reduces the possibility of self-electrocution and requires less frequent surgery to replace the pacemaker battery.



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Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093 —Telephone (312) 446-8440.

THE VIEW BOX

(Continued from page 179)

DIAGNOSIS: Rubella syndrome in infants.

The roentgenographic features in the long bones are considered pathognomonic by some observers. In the newborn these changes consist of a poorly defined provisional zone of calcification and coarsening of the metaphyseal trabecula with longitudinal areas of radiolucency and sclerosis. All of the metaphyseal areas are involved but especially prominent is the region of the proximal tibia and distal femoral epiphysis. The shafts of the bones are essentially normal. If the infant survives and grows satisfactorily the metaphyseal trabecular pattern returns to normal and concomitant with this the provisional zone of calcification shows an increase in density and smoothness. The rapidity and completeness of the regressive bone changes appear to correlate closely with the clinical well being of the infant. In those infants who thrive and maintain normal growth, the bones appear normal at one to three months except for residual growth disturbance lines. Those babies that do not develop normally may show persistance of the irregular growth plate and altered trabeculation of the metaphysis, but the provisional zones of calcification become dense and may even be unusually thick and sclerotic.

Congenital heart disease commonly occurs in infants whose mothers have had rubella during the first trimester of their pregnancy. The most common cardiac anomaly associated with rubella is patent ductus arteriosis. The second most common lesion was pulmonary artery branch stenosis.

Reference:

Singleton, E., Rudolph, A.J., Rosenberg, H.S., and Singer, D.B. The Roentgenographic Manifestations of the Rubella Syndrome in Newborn Infants. *Am. J. Roentgenology, Rad. Ther., and Nucl. Med.* 97 (1):82-91.

The Veterans Administration system of 166 hospitals provides the most complete cross-index of diagnoses and operations in existence for study by medical research personnel.

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PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
SURGERY OF HEAD AND NECK, One Week, September 16
SURGERY OF THE HAND, One Week, September 16
PEDIATRIC SURGERY, One Week, September 30
PROCTOSCOPY & VARICOSE VEINS, One Week, September 9
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY, Sept. 10
SURGICAL & RADIATION Rx OF GYN. MALIGNANCIES, Sept. 9
ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 16
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept. 23
DIAGNOSTIC RADIOLOGY, One Week, September 16
RADIOISOTOPES, One or Two Weeks, First Monday Each Month
BASIC ELECTROCARDIOGRAPHY, One Week, October 7
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Practice of Medicine

(Continued from page 206)

involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.

3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

University of Illinois Medical Center Accepts $448,161 in Grants

The University of Illinois Medical Center accepted an overall total of $448,161 in research and training grants for the month of June. Out of 14 grants listed, 11 grants totaling $429,622 were from the United States Public Health Service.

The funds were allocated as follows: $600 Graduate College and $447,561 College of Medicine. The largest single grant, $111,082, was awarded to Dr. George E. Miller, professor of medicine and Director of the Office of Research in Medical Education by the United States Public Health Service for "The Efficient Use of Medical Manpower."

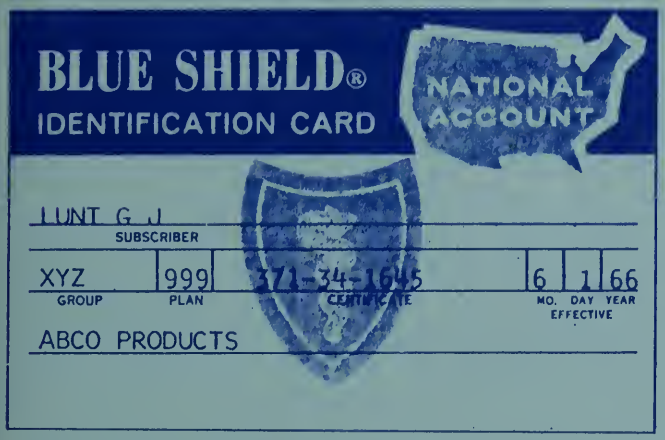
Three quarters of a million veterans receive hospital treatment each year in the 166 Veterans Administration Hospitals.

BLUE SHIELD REPORT FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2 No. 9 September, 1968

New National Account Card



Blue Shield's new National Account ID Card will be seen more frequently in physicians' offices throughout the country as more large national organizations purchase Blue Shield coverage for their employees.

This new Blue Shield identification card looks different from the type issued by the Blue Shield Plan of Illinois Medical Service. It carries the words "Blue Shield Identification Card" and "National Account" across the top.

National Account ID Cards are given to the employees of large national organizations that have purchased Blue Shield coverage under a central certification system.

The National ID Card, as used in connection with central certification, eliminates the necessity to reissue ID Cards when employees move from one Blue Shield Plan area to another.

Central certification is an administrative system developed by Blue Shield to help speed payments to physicians and to provide them and their office assistants with a means of identifying eligible subscribers from outside the local area.

Medical and hospital benefits for employees of centrally-certified groups are uniform regardless of where the individual employee may be located.

When you provide professional services to a patient carrying a National Account ID Card, your office assistant should be instructed to file the claim with the Illinois Blue Shield Plan.

This is particularly important when your patient has a "usual and customary" Blue Shield program, for it will enable us to make proper payment to you, using Illinois definitions of "usual and customary" charge patterns.

Medical Assistants Meetings Underway

The fall dinner meetings for medical assistants got off to a good start August 28 at Pheasant Run Lodge in St. Charles, Illinois.

As part of the ongoing Professional Relations program, the Blue Shield Plan of Illinois Medical Service, for eleven years, has sponsored dinner meetings for medical assistants in the area it serves to help keep them abreast of changes in Blue Shield benefit structures, procedures, and methods, and to help them carry out their responsibilities more effectively for their physician-employers.

Following dinner, the program includes a presentation of our new Blue Shield 65 plan and allows time for questions to be answered by members of our Blue Shield staff from our Medicare, Blue Shield, and Major Medical Departments.

All medical assistants will be invited to attend one of the scheduled meetings and should return promptly the reservation form they receive with their invitations.

Dinners are served at 6:30 P.M. and meetings adjourn promptly at 9:00 P.M. The following dinner meetings have been scheduled:

September 25	McHenry County Club
September 26	Waukegan Inn
October 2	Oak Park Arms
October 3	Lords—Wheeling
October 16	O'Tooles—Shoreland Hotel
October 17	O'Tooles—Shoreland Hotel
October 23	Park Ridge Inn
October 30	Hyatt House
October 31	Hyatt House
November 6	Neilson's Nordic
November 7	Halleran's Restaurant
November 13	Knickerbocker Hotel
November 14	Knickerbocker Hotel

For additional details, please write or telephone Mrs. Loretta O'Donnell, Special Representative, Professional Relations, Blue Shield Plan, 425 North Michigan Avenue, Chicago, Illinois 60611—MO 4-7100, extension 580.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

The following information was excerpted from an important communication on custodial care received from the Social Security Administration.

Physician and Hospital Responsibilities

In order for an extended care facility to provide the care a patient needs, it must know promptly at admission what the condition of the patient is and what treatment it is expected to provide. At the same time, the patient and the facility need to know whether Medicare will pay for the services. In doubtful cases there is a need for prompt decisions on coverage. Otherwise, denial of a claim may mean a patient owes a large sum that is likely to cause a serious problem to him and the facility. This possibility exists when the level of care is not clearly covered and the facility furnishes the intermediary with only the information required by the regular billing procedures. Thus, in doubtful cases, the procedure outlined in Section V should be employed. (Section V has to do with certain forms to be sent to Blue Cross, as intermediary, by the extended care facility.)

The attending physician customarily plans in advance for the needs of his patient, including, where appropriate, transfer from a hospital into an extended care facility. **The hospital can and should aid in this planning process.** In the case of such a transfer, the preferred approach to the provision of patient care information is as follows:

A. While the patient is in the hospital, a medical information summary may be prepared which would include physician's orders for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.

B. This summary should be submitted by the hospital to the facility prior to the time of the transfer of the patient.

C. If the summary is to be incorporated into a form, it may be incorporated into a standard form agreed to by the intermediary and the providers of service. (Blue Cross is developing such a form which will be delivered to extended care facilities).

When this information has not been submitted in advance as indicated above, alternate approaches should be used to supply the needed information. **In every instance, good patient care requires the extended care facility to have available by the time of admission, in writing, the required patient care information.** The written data may in some instances be preceded by telephone orders which would make possible advance preparation for care.

The State agency, the intermediary, and the extended care facility should do all they can to encourage hospitals to transfer this medical information to the facility by the time of admission.

ANNOUNCEMENT

The Civil Service Commission will enroll federal employees in Illinois Blue Shield's superior "Usual and Customary" program effective January 1, 1969.

Until then, federal employees in the state will continue to be protected by Blue Shield's indemnity certificate.

NOTICE

To help speed Medicare payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

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DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

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10 mg. Methamphetamine Hydrochloride,
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DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



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Please see Brief Summary on next page.

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Brief Summary

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DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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by Paul deHaen

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Combination Products—Drugs consisting of two or more active ingredients.

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Contraindications: Hypersensitivity to penicillin.
Dosage: Adults and children over 88 lbs.—125 to 250 mg. q6h. Children under 88 lbs.—12.5 to 25 mg./kg./day in divided doses, q6h.
Supplied: Capsules—125 and 250 mg., bottles of 24 and 100. Powder for Oral Suspension—62.5 mg./5 cc., bottles of 80 cc.

MYOCON Granucaps Vasodilator-Coronary ℞
Manufacturer: S.J. Tutag Company
Nonproprietary Name: Nitroglycerin
Indications: Management of angina pectoris. Not intended for immediate relief of anginal attacks.
Contraindications: Early myocardial infarction, severe anemia, glaucoma, increased intracranial pressure.
Dosage: One capsule q12h., may be increased to q8h. For oral use, not sublingual.
Supplied: Capsules, sustained release—2.5 mg.

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Manufacturer: Rowell Laboratories
Composition: a-amylase 20 mg.
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Indications: Digestive disturbances due to overeating, age, illness, surgery, pregnancy, or nervous indigestion.
Contraindications: Hypersensitivity to any of the ingredients.
Dosage: 1 to 2 capsules tid, with meals.
Not for children under 6 yrs.
Supplied: Capsules—bottles of 100, 500, and 1,000.

(Continued on page 246)

In peptic ulcer: the antacid puzzle



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The president's page



Philip G. Thomsen, M.D.

"Corporate practice of medicine"—that may sound like too high-blown an expression to alarm us.

But alarm us it does—because it threatens the right of the physician to be his own man, his own guide. We must battle any effort by hospitals to dominate our professional and economic lives . . . our ties to our patients.

Just what is the nature of this battle, though? In recent months it has changed.

We felt, at first, that we faced a challenge from the Illinois Hospital Association. But conferences with IHA have been fruitful in eliminating any organized desire to expand salaried hospital practice.

Now a real and growing threat to the continued independence of physicians is from individual hospitals with full-time paid staffs . . . primarily teaching hospitals. Many of these institutions seek to draw on Medicare/Medicaid funds under their own billing and fee-payment setup . . . and put the money into a corporate "slush fund."

Medicare fees for a physician's services, of course, are intended for him, not the hospital. To get around this obstacle, the teaching hospitals might simply put an administrative physician's name on the bill . . . make it seem that he had performed the service.

Needless to say, such a subterfuge raises a tax question for the doctor whose name appears on the bill . . . and a question of legal responsibility for the patient's care.

The whole ruse clearly would violate a report given the AMA annual convention last year and declaring, in part:

"Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency."

This report spelled out acceptable ways in which staffs—including men with private practice as well as salaried doctors and faculty—could coordinate fees. As a whole or by department, the staff could form its own group which "would collect, control and disburse all income generated by its activities. Disbursement would be according to a plan previously agreed upon."

To make sure that any collective billing at the University of Illinois hospitals would follow such a plan, your society was instrumental in getting the General Assembly last year to pass House Bill No. 25.

We must be vigilant and active to prevent other teaching hospitals from using Medicare as a road to corporate practice. We must encourage medical staffs to follow the AMA—and UI—formulas. A court challenge of some of the subterfuges may be in order.

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Philip G. Thomsen M.D.

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Riboflavin	5.0 mg.	—
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(Continued from page 224)

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Contraindications: Acute glaucoma, advanced renal or hepatic disease, biliary tract obstruction, or hypersensitivity to any of the ingredients.
Dosage: One capsule with each meal.
Supplied: Capsules—bottles of 100, 500, and 1,000.

SYNOPHYLATE-GG Syrup Bronchial Dilator ℞
Manufacturer: Central Pharmacal Company
Composition: Each 15 cc. contains: Theophylline sodium glycinate 300 mg.
Glyceryl guaiacolate 100 mg.
Indications: Symptomatic treatment of bronchial asthma and other bronchospastic conditions.
Contraindications: Hypersensitivity to any of the ingredients.
Dosage: Adults—1 to 2 tbsp., q4-8h. Children 6-12 yrs.—2 to 3 tsp., q4-8h. Children under 6 yrs.—¼ to ½ tsp./10 lbs. body wt., q4-8h.
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Manufacturer: S.F. Durst & Co., Inc.
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Indications: Differential diagnosis of pregnancy and functional amenorrhea.
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MACRODANTIN Antibacterial-Urinary
Manufacturer: Eaton Laboratories
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Indications: Infections of the genitourinary tract, i.e. pyelonephritis, pyelitis, cystitis, and prostatitis due to susceptible organisms, as shown by culture and sensitivity testing.
Contraindications: Anuria, oliguria, hypersensitivity to the drug, pregnancy at term, infants under one month of age, nursing mothers.
Dosage: 100 mg. qid, with meals, for 10-14 days. for individuals of less than average size: 5-7 mg./kg./24 hrs. in 4 divided doses, not to exceed 400 mg./day.
Supplied: Capsules—50 and 100 mg., bottles of 30, 100, and 500.

TINACTIN Powder Fungicide-Topical ℞
Manufacturer: Schering Corporation
Nonproprietary Name: Tolnaftate
Indications: Fungous infections of intertriginal and other naturally moist skin areas in which drying may enhance the therapeutic response.
Contraindications: None mentioned.
Dosage: Apply locally twice a day for 2 to 3 weeks, alone or adjunctively with Tinactin solution of cream.
Supplied: Powder—1%, 45 gm. plastic container.

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Date Entered Medical School _____
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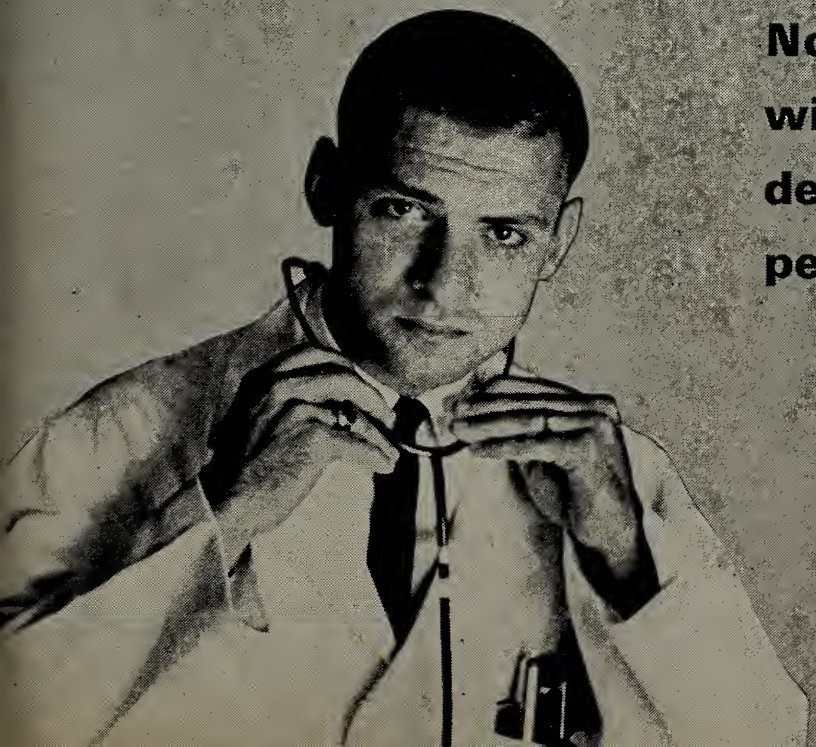
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25	35.00	18.00	36.00	18.50
26	35.50	18.50	36.50	19.00
27	36.00	18.50	37.50	19.50
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Primary Source of Surfactant Found by Chicago Scientist

The primary source for production of the substance which keeps 300 million small air spaces in the lung from collapsing is a group of cells never before thought to be involved in the process.

According to the scientist at The University of Chicago who made the discovery, the production of that lung-coating substance, surfactant, can now be studied and surfactant itself may perhaps eventually be controlled.

Dr. Albert H. Niden, Associate Professor of Medicine, said that surfactant has been implicated in hyaline membrane disease in newborn infants. "It has been fairly well accepted, but not established," he said, "that not enough surfactant is produced in infants suffering from this disease."

Dr. Niden's finding offers a new opportunity to explore the role of this pulmonary substance in hyaline membrane disease. A reduction in surfactant activity has been found in every pulmonary pathologic condition in which it has been studied, Dr. Niden said. A decrease in surfactant production has been implicated as causing lung collapse in such other conditions as pneumonia, pulmonary emboli or blood clots, and respiratory insufficiency.

Nature Known 10 Years

The role of the phospholipid substance in healthy lungs has been known for about 10 years, according to Dr. Niden, although its exact nature was unknown.

Until Dr. Niden's discovery, surfactant was considered to be produced primarily in the cells around the small air spaces, or alveoli. "This assumption," he said, "was made because globules of lipid, presumably surfactant, were seen to be 'secreted' by these cells. By radioactive tracing we now know that these globules viewed in nonliving specimens were actually in the process of being engulfed rather than secreted."

The main source of the substance, he said, is really the Clara cells lining the terminal airways of the lungs.

Dr. Niden began his research project, which is sponsored by the U.S. Public Health Service, with the belief that the Clara cells in the bronchial tree were likely candidates for production of surfactant.

Doubts Importance of Substance

To check his hypothesis, he spent three years tracing carbon particles and radioactive fatty acids in the lung using an electron microscope. By injecting radioactive fatty acids into mice and then fixing sections of lung samples over a period of time, he traced the path of surfactant production from the Clara cells to the lung lining and into the large alveolar epithelial cells which absorbed, or phagocytized, the substance.

While Dr. Niden is currently experimenting on control of surfactant and the possibility of stimulating its production, he has some doubts as to the importance of this substance in disease.

"Previous experiments which have implicated surfactant in disease are not completely reliable," he said. "For example, animal lungs have been washed out to obtain surfactant which was then tested on a surface tension balance. The results showed the substance to be decreased in almost any disease state of the lungs. However, the decrease may well follow the illness rather than be its cause. By the same token, the mucous and edema occurring in many diseases may inhibit surfactant activity or by blocking the small air space may prevent adequate extraction by lung washings, thus reducing the quantity extracted."

Pinning the production source down now offers an opportunity to study directly the role of surfactant.

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Illinois Medical Journal
volume 134, number 3 September, 1968

Primary Pulmonary Sporotrichosis In Illinois

A Case Report

First epidemiological link to Spagnum Moss

By William H. McCain, M.D., and Walter F. Buell, M.D./Quincy

Pulmonary infection due to *Sporotrichum shenkii* in the absence of cutaneous involvement has been encountered rarely. The recent case report by Cruthirds and Patterson[1] is believed to be the nineteenth on record. Although the more common lymphocutaneous form of sporotrichosis has been found related to sphagnum moss by a number of epidemiologic studies, recently reviewed by D'Alessio, et al.,[2] no similar relationship has been noted in the cases with primary pulmonary involvement. The present case is submitted as the twentieth primary pulmonary case of sporotrichosis and the *first to be epidemiologically linked to sphagnum moss.*

Case Report

The patient, a 59-year-old, white, service station operator was first admitted to Hillcrest Sanatorium, Quincy, on Nov. 21, 1964. Approximately one month prior to admission he had entered another hospital for an elective surgical procedure. At that time he had lost 30 pounds from his previous weight of 180 pounds. He described a gradual loss of weight beginning in the spring of 1964. During the hospitalization a persistent fever was noted, and a chest x-ray suggested pulmonary inflammation; he admitted a chronic cough. In the absence of improvement on an antibiotic regimen, a bronchoscopic exam was performed. Bronchial washings were reported positive, by smear, for acid fact bacilli, and a tuberculin skin test was positive. He was then transferred to Hillcrest Sanatorium with a diagnosis of active tuberculosis, and therapy was begun with streptomycin and isoniazid. His temperature returned to normal within one week and he began to improve generally. Over the next 6 months continued improvement was noted on antituberculous therapy, and chest x-rays cleared considerably (Fig. 1). Sputum cultures, including cultures of the smear-positive bronchial washings, were never positive for *M. tuberculosis*. He was discharged on May 27, 1965.

On November 29, 1966, he was re-admitted for evaluation of persistent pulmo-

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Walter F. Buell, M.D., is Medical Epidemiologist, Epidemic Intelligence Service, National Communicable Disease Center, assigned to the Illinois Department of Public Health, Springfield. He received his M.D. from the University of Texas and served his post M.D. training at the University of Pittsburgh Health Center Hospitals.

nary infiltrate. The chest x-ray showed increased infiltrate, compared with films of the previous admission. Tuberculin and histoplasmin skin tests were positive. Sputum culture for tubercle bacilli was negative; a serologic test for histoplasmosis revealed a yeast phase complement fixation titer of 1.8. Fungus culture of sputum on May 26, 1967, was positive for *Sporotrichum shenkii,* and five subsequent specimens were positive. The patient denied any history of chronic skin lesions typical of cutaneous sporotrichosis. Treatment with saturated solution of potassium iodide was initiated, and continued until discharge on October 11, 1967. During this period, sputum cultures remained positive for *S. senkii* despite symptomatic improvement and weight gain. Following discharge he was to have further evaluation of the pulmonary sporotrichosis by his private physician. Chest x-rays taken during this second admission are shown in Fig. 2.

Epidemiologic Investigation

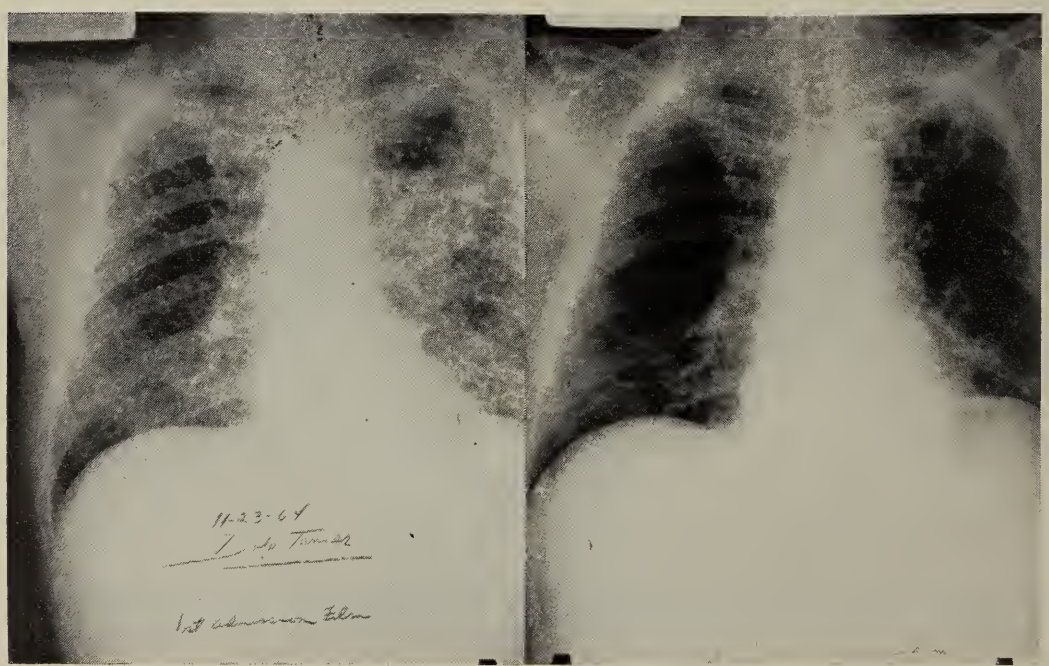
The patient has been a resident of western Illinois and Missouri for the past 30 years. His occupation during this period has been oil refinery and service station work. Although he related hobbies of hunting and fishing, he denied outdoor activities of this type since 1960. He had never worked in a nursery or florist shop. He clearly recalled contact with peat moss on two distinct occasions, one of which was in 1935. In the fall of 1963 he purchased a 50-pound bag of peat moss at a grocery store in Jefferson City, Mo. Part of this moss was spread over his lawn in the spring of 1964. Subsequently, following separation from his wife, he moved to Illinois in the summer of 1964. He brought with him the remainder of the peat moss which was given to a cousin in Quincy. The remainder of the moss was used by the patient's cousin.

The source of the peat moss was traced from the grocery store in Jefferson City. The manager of the store, who had held his position for over 10 years, related the specific brand of the moss and the supply agent. This was traced to the peat company whose product in 1963 came from only two peat bogs in Michigan. It was noted that one of these bogs contains sphagnum moss, which could therefore have been included in the commercial peat moss product.

Mycologic studies of the soil in the yard of the patient's cousin, who had spread the moss three years previously, were negative for *S. shenkii.* Due to the extended interval between the patient's contact with moss and the investigation, no mycologic studies with material from the peat bogs were attempted.

FIG. 1: A Case of Pulmonary Sporotrichosis in Illinois: Chest X-ray at the Beginning and End of First Hospital Admission.

Admission **Discharge**



Discussion

The lymphocutaneous form of sporotrichosis has commonly aroused the interest of epidemiologists. Because of the nature of *S. shenkii* and its transmission, a determined investigation almost always unearths an explanation for the presence of the fungus in a given lesion. The discovery that sphagnum moss is an important factor in the chain of infection has added still another avenue of attack.

Although direct inhalation has been suspected to be the mode of transmission[7] of primary pulmonary sporotrichosis, no clear-cut reservoir has been implicated. The extreme rarity of the disease, combined with the chronicity and difficulty in diagnosis, are all significant limiting factors in the understanding of the mechanism of transmission.

Table 1 lists pertinent epidemiologic factors from previous case reports. A comparison of these factors is not fruitful, since most reports were concerned with the diagnosis and treatment of this rare disease rather than the transmission of the fungus. Nevertheless, several of the cases, especially case 16 (the florist), may well have contacted sphagnum moss and thereby inhaled the fungus.

The present case is thought to be the first primary pulmonary sporotrichosis case linked to sphagnum moss. Although the link is somewhat tenuous, due to the length of time between initial exposure and culture diagnosis, the lucidity of the history given by this patient seems to clearly place his handling of peat moss in the period immediately prior to the first manifestations of his illness. Information obtained from the patient, who had extremely good recall of events, indicated that the period in the spring of 1964 following the breakup of his family was a trying time for him. The evidence, obtained from the distributors of the commercial product, that sphagnum moss was indeed present in one of the two bogs from which the product was harvested serves to corrobrate and strengthen the theory of the relationship.

Summary

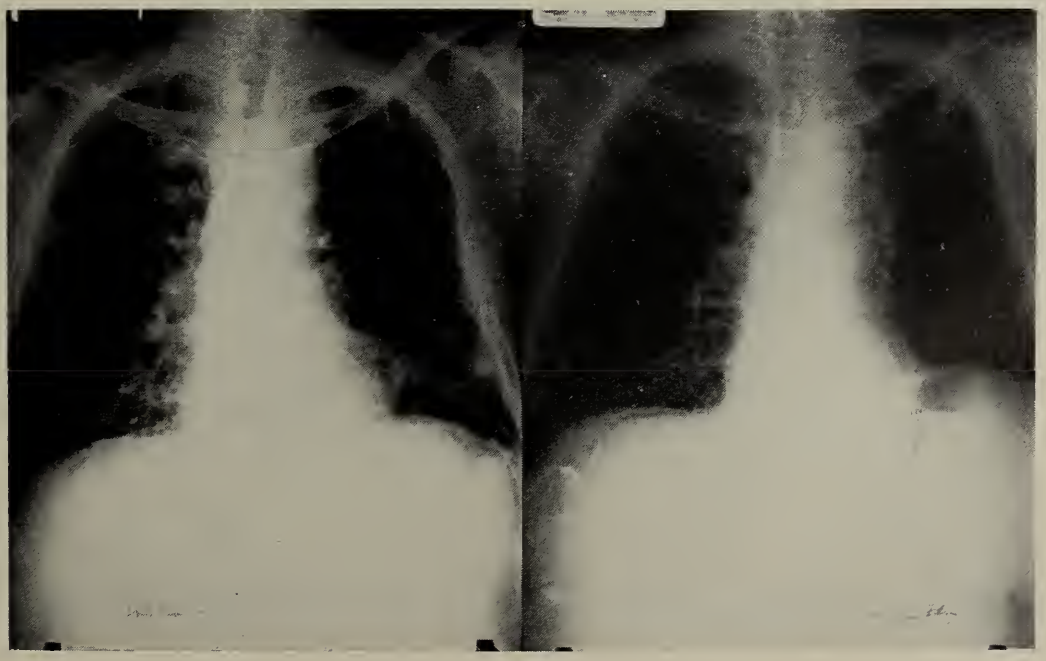
A case of primary pulmonary sporotrichosis is described in a 59-year-old, Illinois, service station operator. Epidemiologic evidence implicates the source of infection as a commercial peat moss product containing sphagnum moss.

References

1. Cruthirds, T. P., and Patterson, D. O., Primary Pulmonary Sporotrichosis, *Journal of Respiratory Diseases,* (May 1967) p. 845
2. D'Alessio, D. J., Leavens, L. J., Strumpf, G. B., and Smith, C. D., An Outbreak of Sporotrichosis in Vermont Associated with Sphagnum Moss as the Source of Infection, *New Eng. J. of Med.,* 272: 1054-1058, 1965

FIG. 2: A case of Pulmonary Sporotrichosis in Illinois: Chest X-ray at Beginning and End of Second Hospital Admission.

Admission **Discharge**



3. Ridgeway, N. A., Whitcomb, F. C., Erickson, E. E., Law, S. W., Primary Pulmonary Sporotrichosis, *Am. J. of Med.*, 32, 153-160, 1962
4. Scott, S. M., Peasley, E. D., Crymes, T. P., Pulmonary Sporotrichosis, *New Eng. J. of Med.*, 265, 453-457, 1961
5. Siegrist, H. D., Ferrington, E., Primary Pulmonary Sporotrichosis, *Sou. Med. J.*, 58, 728-735, 1965
6. Trevathan, R. D., Phillips, S., Primary Pulmonary Sporotrichosis, *JAMA*, 195, 965-967, 1966
7. Smith, D. T., *The Chest*, edited by Myers and McKinlay, Charles C. Thomas, publisher, Springfield, Ill., p. 262, 1948

Table 1
A Summary of Reported Cases of Primary Pulmonary Sporotrichosis

1.	I	—	—	—	—	—
2.	II	40	F	—	—	—
3.	III	—	—	—	tobacco buyer	—
4.	IV	—	—	—	—	—
5.	V	34	F	—	—	—
6.	VI	—	—	—	Pharmacist	worked with tobacco leaves
7.	VII	—	—	—	—	—
8.	VIII	57	M	—	—	—
9.	IX	11	M	—	—	—
10.	X	10	F	—	—	—
11.	XI	50	M	—	—	—
12.	XII	—	—	—	farmer	—
13.	Ridgeway, et al.[3]	35	M	White	brick mason	illness probably began in 1939 while patient in Washington state
14.	Ridgeway, et al.[3]	30	M	Negro	beer truck worker	hunted & fished 2-3 times monthly in southwest Louisiana
15.	Scott, et al.[4]	26	M	—	x-ray technician	—
16.	Scott, et al.[4]	42	M	Negro	florist	—
17.	Siegrist & Ferrington[5]	43	M	White	salesman for salt co.	worked on Florida tomato ranch for 3 mo., otherwise worked in Miss. as salesman or service station attendant
18.	Trevathan & Phillips[6]	40	M	White	salesman	lived in urban communities, two deer-hunting trips prior to onset
19.	Cruthirds & Patterson[1]	61	M	White	heavy equipment operator	—

Information on cases 1-12 taken from review by Ridgeway, et al. [3]

Abortion in Japan

The enactment of the Eugenic Protection Act in Japan was followed by many changes. The population explosion was stemmed, the birth rate was halved, and while the marriage rate remained steady the divorce rate declined. The annual total of abortions increased until 1955 and then slowly declined. The highest incidence of abortions in families is in the 30 to 34 age group when there are four children in the family. As elsewhere abortion in advanced stages of pregnancy is associated with high morbidity and mortality.

There is little consensus as to the number of criminal abortions. Reasons for criminal abortions can be found in the legal restrictions concerning abortion: licensing of the abortionist, certification of hospitals, taxation of operations and the requirement that abortion be reported. Other factors are price competition and the patient's desire for secrecy.

Contraception is relatively ineffective as a birth control method in Japan. Oral contraceptives are not yet government approved. In 1958 alone 1.1 per cent of married women were sterilized and the incidence of sterilization was increasing. (Legalized Abortion in Japan. Thomas M. Hart, Calif. Med. (Oct.) 1967; pg. 334).

An Outbreak of Histoplasmosis in Illinois Associated with Starlings

By Robert M. Younglove, M.D., Richard M. Terry, M.D., Norman J. Rose, M.D., M.P.H., Russell J. Martin, D.V.M., M.P.H. and Paul R. Schnurrenberger, D.V.M., M.P.H.

The organism *Histoplasma capsulatum* was first isolated in 1906, from the spleens of three patients who had succumbed to the infection;[1] however, it was 1934 before a human case was diagnosed prior to death[2] and the organism cultured and identified as a fungus.[3] Fifteen years elapsed before the first isolation of *H. capsulatum* from a non-animal, environmental source; Emmons[4] in 1949 recovered the organism from soil collected from around a rodent burrow under a chicken coop.

H. capsulatum is a natural inhabitant of the soil and thrives in areas contaminated with avian excreta. The organism is generally believed to be transmitted to man from the natural environment, and the clinical picture appears to be affected by the frequency and degree of exposure to infection. For years this fungal infection of the lungs has occurred in individuals who have been associated with caves,[5] storm cellars,[6] or silos[7] whose soils were contaminated with the organism. Also, infections have occurred in individuals who recently have cleaned abandoned chicken houses[8,9] bell towers,[10] water towers[11] or church belfries[12] inhabited by birds. Any of these latter situations provide a large volume of bird droppings, an excellent medium for the growth of the fungus. Persons working in these confined areas get infected by breathing dust with large numbers of *H. capsulatum* spores.

More recently there have been histoplasmosis outbreaks under markedly different circumstances. Individuals involved in these outbreaks have been exposed in open areas, and the bird implicated has been the starling (*Sturnus vulgaris*).[13-15] This report describes such an epidemic which occurred in a northwestern Illinois city of 16,000.



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LOCATION OF SOIL COLLECTIONS FROM SUSPECT PREMISES: ILLINOIS HISTOPLASMOSIS OUTBREAK -- 1963

0 -- Negative Soil Sample

X -- Positive Soil Sample

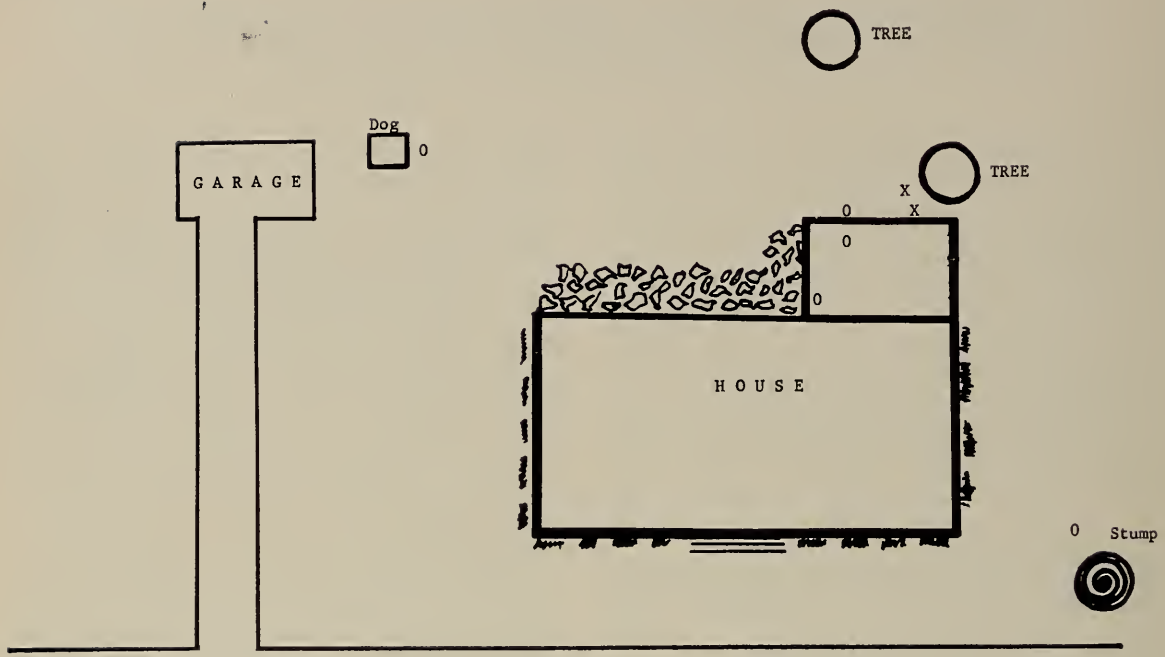


Fig. 1

DURATION OF ILLNESS AND EXPOSURE TO SUSPECT PREMISES IN AN ILLINOIS HISTOPLASMOSIS OUTBREAK

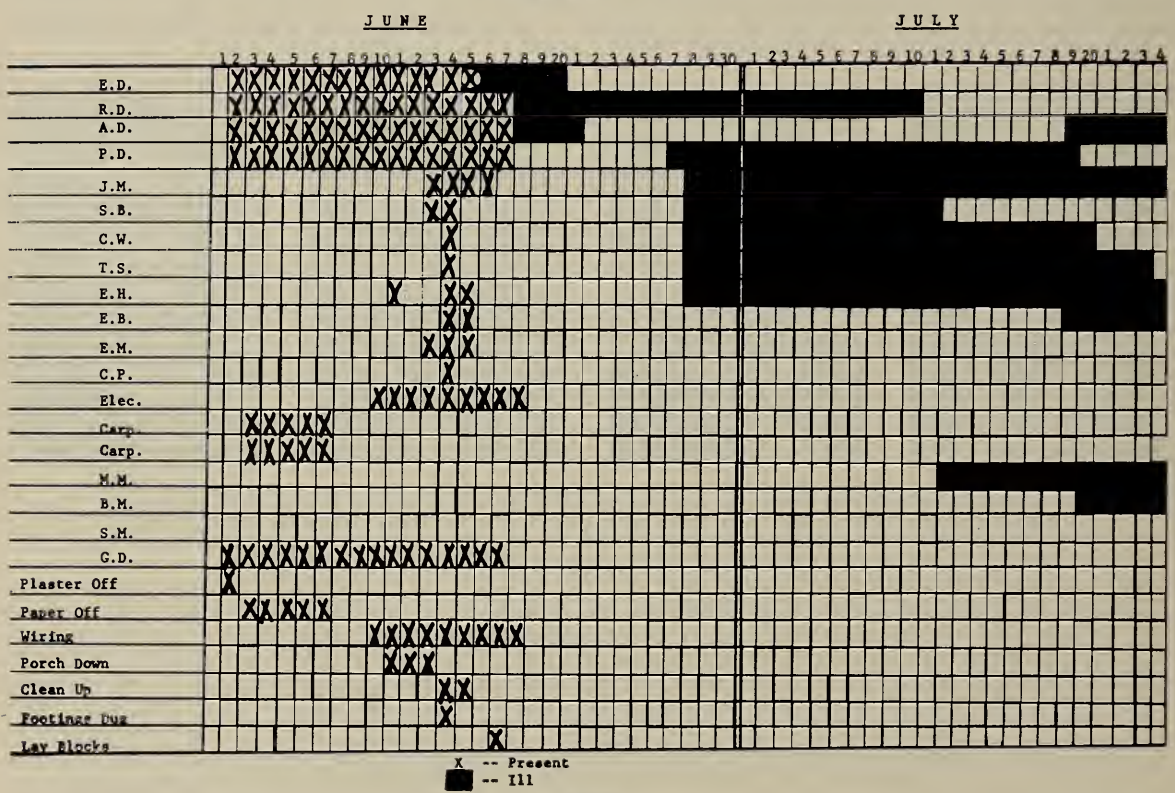


Table 1

History

The epidemic reported here centers around a 50-year-old home (Fig. 1) that was undergoing remodeling. The house was purchased by Family D in the spring, and remodeling began in early June. On various dates members of the neighboring household, Family M, assisted Family D with the work. Also, at times friends and commercial laborers were present at the work site.

Part of the remodeling procedure involved removal of an old back porch and the construction of a new enlarged porch on the same site. Dates of the various activities and the individuals that were present on these dates are listed in Table 1.

The initial case (E.D.) was in an eight-year-old white male who, on June 15, presented with malaise, 103°F. temperature, headache, pallor, fatigue, severe chills and night sweats (Table 2). He lost 8 pounds during the three-week illness and a convalescent serum sample titered 1:256 against the yeast phase of *H. capsulatum* in the complement fixation text (CFT). He was not skin tested with histoplasmin.

Three days later, the father (R.D.) of this patient, a forty-year-old executive, had a sudden onset of illness with severe chills, extreme exhaustion, a fever of 103.4°F., anorexia, night sweats, and tightness in the chest. A radiograph taken on the second day of illness revealed multiple vague localized areas of increased opacity in both lungs. These varied in size, from 5 mm. in diameter upward. Very few were clear-cut or distinct. Although the patient had a positive tuberculin test, it was the opinion of the radiologist that the findings were not due to active tuberculosis. The histoplasmin skin test was positive, and a convalescent serum collected from the patient titered 1:64 (CFT). The patient lost approximately 5 pounds during his one month illness.

R.D.'s eleven-year-old daughter (A.D.) developed a headache, fever of 102.4°F., general malaise, light chills, and sweating on the same evening that her father became ill. She also complained of a mild abdominal discomfort. The patient did not react to tuberculin; however, a positive reaction was noted against the standard histoplasmin skin antigen. A radiograph taken in approximately the fifth week of illness showed minimal lesions in the lower part of one lung. A routine radiograph of this patient taken five years earlier had shown numerous discrete calcifications involving portions of all lobes of both lung fields which were believed to have been due to histoplasmosis.

Twelve persons were clinically ill during the course of the outbreak (Table 2). Ten of these individuals had been involved in remodeling the old house purchased by the D Family. Interview of these persons revealed that June 14 was the only day all the persons who got sick had been present at the house (Table 1). On June 14 the children (A.D., E.D., S.B., C.W., T.S., J.M.), had removed the wreckage of the back porch, which had been torn down on the 13th, and disposed of it by burning or dumping it into an old cistern. Adults (R.D., P.D., E.H., E.B.) dug the footings for the new porch on this date. The other two clinical cases (M.M. and B.M.), occurred in the wife and daughter of E.M. In addition to living next door to the suspect house, these two individuals had laundered clothing worn by J.M. and E.M. during the remodeling operations June 14.

There were seven other persons (E.M., C.P., S.M., G.D., two carpenters, one electrician) who had either direct or indirect exposure at the house (Table 1). Skin tests performed on three (E.M., S.M., G.D.) of these persons were positive. Blood samples collected from two of these persons (E.M., S.M.), were reactive to the complement fixation test for *Histoplasma*. No tests were performed on the other four persons. Two of these were carpenters, one was an electrician, and the fourth was a contractor (C.P.). The two carpenters were not present on June 14. These two individuals and the electrician also had been working inside the house and thus had not been in direct contact with the back porch area. The contractor worked at construction sites constantly and might be expected to have some immunity to histoplasmosis from previous exposures.

A visit was made to the residence, and soil samples were collected from eight spots (Fig. 1). The soil samples were split and one-half of each sample was examined by the laboratories of the Illinois Department of Public Health. The other half was examined at National Institute of Allergy and Infectious Diseases through the court-

SUMMARY OF CLINICAL AND DIAGNOSTIC FINDINGS
Illinois Histoplasmosis Outbreak
1963

	PATIENT											
	R.D.	C.W.	P.D.	T.S.	S.B.	J.M.	A.D.	E.D.	E.B.	E.H.	M.M.	B.M.
Fever	103^4	105^4	104^8	105	103	+	102^4	104^2	+	103^8	103^8	102^8
Fatigue	+	+	+	+	+	+	+	+	+	+		
Chills	+	+	+				+	+		+	+	+
Chest Pain	+	+	+	+	+	+			+			
Malaise	+	+		+	+	+	+	+				+
Pallor	+	+	+	+	+		+	+				
Weight Loss	+	+	+	+	+	+		+				
Sweating	+	+	+		+		+	+				
Headache		+		+	+		+	+		+		
Anorexia	+	+	+	+	+	+			+			
Cough	+		+	+		+					+	
Weakness	+		+	+		+						
Tight Chest	+		+						+			
Sore Throat		+			+							
Vomiting						+			+			
Dizziness	+											
Sore Eyes		+										
Reciprocal of CF Titer (Yeast Phase)	64	32	512	128	512	256	128	256	ND	ND	128	64
Radiograph	+	ND	+	+	ND	+	+	ND	ND	+	+	ND
Skin Test	+	ND	ND	ND	ND	+	+	ND	ND	ND	+	+

ND= Not Done

Table 2

esy of Dr. C. W. Emmons, Chief, Medical Mycology Section, National Institute of Allergy and Infectious Diseases. The findings from the two laboratories were identical. *Histoplasma capsulatum* was isolated from only the two samples collected under a tree in the backyard. This particular tree, a large elm, had been the favorite roost of starlings in that part of town for a number of years. The tree shaded the back porch.

There was no similar illness in other residents of the city during the period of the outbreak.

Comments

Epidemiologic evidence certainly incriminates the remodeling operation as the precipitating factor in this epidemic. The accumulation of starling droppings around the area of the old back porch provided adequate medium for the growth of the fungus. The clean-up operation and digging activities on June 14 created the dusty environment conducive to the transportation of the *Histoplasma capsulatum* spores into the victims' lungs.

The onset dates (Table 1) suggest the possibility of three different exposure periods. Patients E.D., A.D. and R.D. became ill within a three-day period (June 15-18). All three individuals were present at other remodeling operations (June 2-June 13) and thus may have been exposed earlier. There is strong evidence that six (P.D., J.M., S.B., C.W., T.S., E.H.) of the active cases obtained their infections on June 14. These six individuals became ill June 27 or June 28. Cases M.M. and B.M. laundered clothing on June 22 that had been worn on June 14; therefore, their probable exposure date was actually June 22. E.B. was not a resident of the city; therefore, it was difficult to obtain exact details surrounding his illness. Family D related that they experienced an illness clinically similar to those described earlier in this report and that his onset of illness was July 19. If his illness was histoplasmosis it is difficult to explain the long incubation period associated with his illness, unless E.B. also obtained infection from contaminated fomites (for example, dirty clothing worn June 14).

Undoubtedly, *H. capsulatum* can be found in many other similar areas in Illinois. These microfoci of infection are potentially dangerous only if they contain large numbers of *H. capsulatum* spores and if the area is disturbed sufficiently to produce a suspension of the organism in the air. When used as described by Tosh[16], formaldehyde will decontaminate the surfaces of these areas for practical purposes. This procedure will rid the top three to four inches of soil of demonstrable *H. capsulatum* organisms. Usually the major limiting factor in the use of this particular technique is the size of the area to be treated. If the area is large, the cost of materials may prohibit the use of this method.

Investigation of this particular outbreak of histoplasmosis demonstrates the effectiveness of a team approach to certain health problems. A prompt and accurate diagnosis followed by rapid reporting on the part of the attending physician enabled public health agencies to contribute early epidemiologic assistance. The public health laboratory conducted complement fixation tests using the sera collected from the patients. These results confirmed the attending physician's diagnoses and also supplied valuable information to the epidemiologist. Soil culture services furnished by the laboratory provided proof that *H. capsulatum* organisms were present at the remodeling site. Thus, many facets of an epidemic situation can be tied together when contributions are made by several interested disciplines.

References

1. Darling, S.T.: A Protozoan General Infection Producing Pseudotubercles in the Lungs and Focal Necrosis in the Liver, Spleen and Lymph Nodes. JAMA 46:1283, 1906.
2. Dodd, K. and Tomkins, E.H.: Histoplasmosis of Darling in an Infant. Amer. J. Trop. Med. 14:127, 1934.
3. DeMonbreun, W.A.: Cultivation and Cultural Characteristics of Darling's *Histoplasma capsulatum*. Amer. J. Trop. Med. 14:93, 1934.
4. Emmons, C.W.: Isolation of *Histoplasma capsulatum* from Soil. Public Health Reports. 64:892, 1949.
5. Washburn, A.M., Tuohy, J.H., and Davis, E.L.: Cave Sickness: A New Disease Entity? A.J.P.H. 38:1521, 1948.
6. Cain, J.C., Devins, E.J., and Downing, J.E.: An Unusual Pulmonary Disease. Arch. Int. Med. 79:626, 1947.
7. Grayston, J.T., Loosli, C.G., and Alexander, E.R.: The Isolation of *Histoplasma capsulatum* from Soil in an Unusued Silo. Science. 114:323, 1951.
8. Idstrom, L.G., and Rosenberg, B.: Primary Atypical Pneumonia. Bull. U.S. Army M. Dept. 81:88, 1944.
9. Grayston, J. T., and Furcolow, M.L.: The Occurrence of Histoplasmosis in Epidemics—Epidemiological Studies. A.J.P.H., 43:665, 1953.
10. Nauen, R., and Korns, R.F.: A Localized Epidemic of Acute Miliary Pneumonitis Associated with the Handling of Pigeon Manure. Paper read at the Annual Meeting of the APHA (Oct.), 1944.
11. Feldman, H.A., and Sabin, A.B.: Pneumonitis of Unknown Etiology in a Group of Men Exposed to Pigeon Excreta. J. Clin. Investigation. 27:533, 1948.
12. Parrott, T., Jr., Taylor, G., Poston, M.A., and Smith, D.T.: An Epidemic of Histoplasmosis in Warrenton, North Carolina. Southern Med. J. 48:1147, 1955.
13. Furcolow, M.L., Tosh, F.E., Larsh, H.W., Lynch, H.J., Jr., and Shaw, G: The Emerging Pattern of Urban Histoplosmosis: Studies on an Epidemic in Mexico, Missouri. New England J. Med. 264:1226, 1961.
14. D'Alessio, D.J., Heeren, R.H., Hendricks, S.L., Ogilvie, P.H., and Furcolow, M.L.: A Starling Roost as the Source of Urban Epidemic Histoplasmosis in an Area of Low Incidence. American Review of Respiratory Diseases. 92:725, 1965.
15. Tosh, F.E., Doto, I.L., D'Alessio, D.J., Medeiros, A.A., Hendricks, S.L., and Chin, T.D.Y.: The Second of Two Epidemics of Histoplasmosis Resulting From Work on the Same Starling Roost. American Review of Respiratory Diseases. 94:406, 1966.
16. Tosh, F.E., Weeks, R.J., Pfeiffer, F.R., Hendricks, S.L., and Chin, T.D.Y.: Clinical Decontamination of Soil Containing *Histoplasma capsulatum*. American Journal of Epidemiology. 83:262, 1966.

THE VIEW BOX

By Leon Love, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School

This 6-year-old boy entered the hospital with chief complaint that he had felt a sudden sharp pain in his left knee while running. Physical examination revealed tenderness in the region of the proximal tibia.

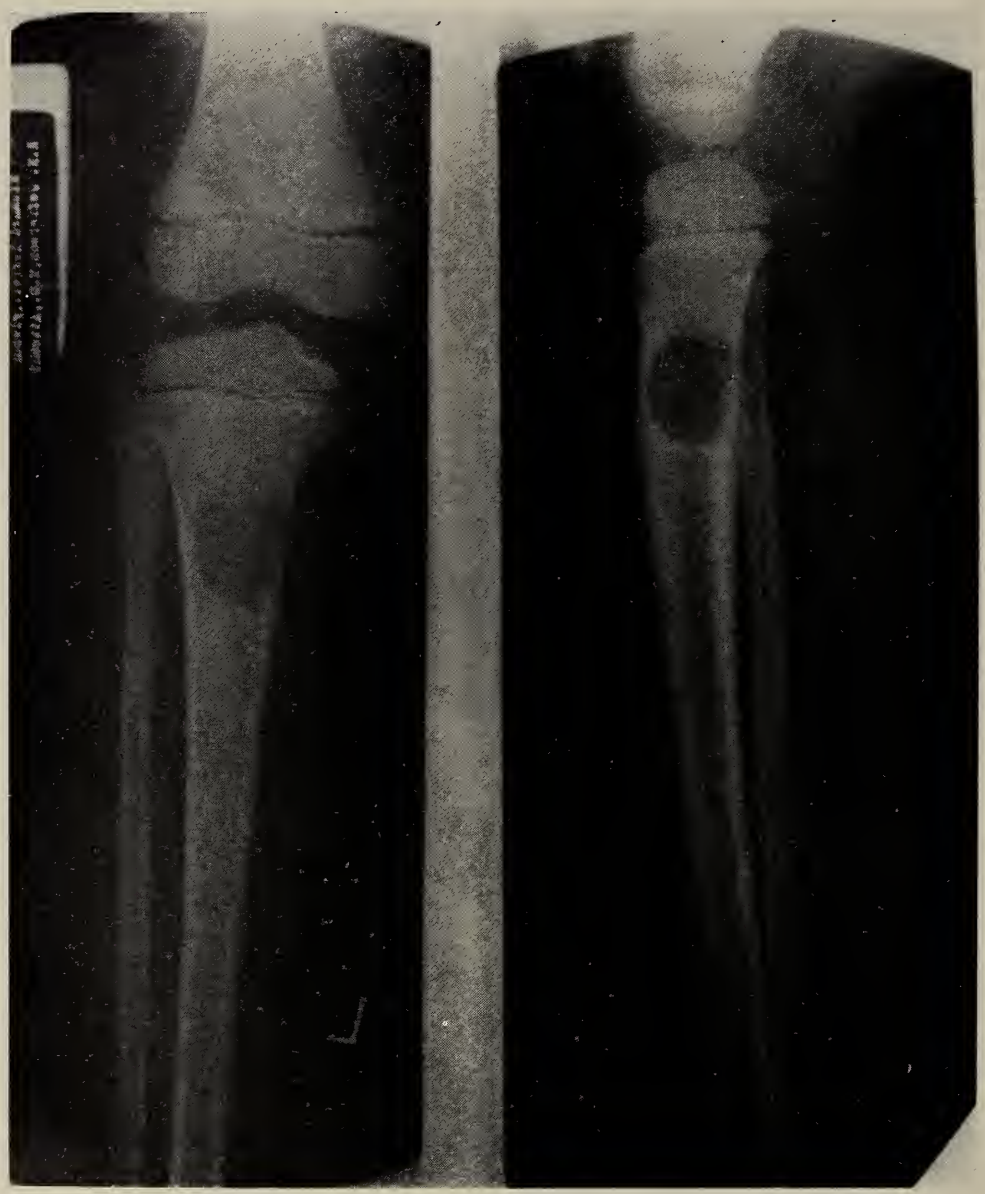


Fig. 1

What's your diagnosis?

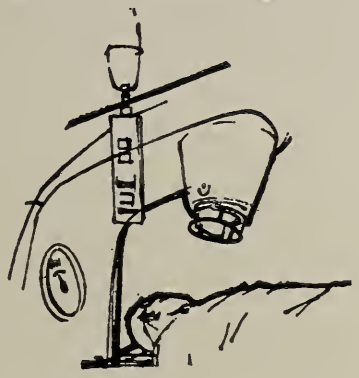
1) Eosinophilic granuloma.
2) Enchondroma.
3) Fibrous dysplasia.
4) Solitary bone cyst.

(Answer on page 309.)

Medical Progress in the Use of Drugs in Pregnancy

By Roy M. Pitkin, M.D./Chicago

Medical Progress



Harvey Kravitz, M.D.
Medical Progress Editor

It has long been recognized that virtually any drug administered to a pregnant woman is actually given, for good or ill, to two individuals. However, full realization of the significance of this concept has only come recently, largely as a result of the thalidomide disaster. The widespread publicity attendant upon that particular therapeutic misadventure, with its results as dramatic as they were tragic, has markedly increased the level of awareness of the possible harmful effects of drugs in pregnancy.

Adverse effects of drugs in pregnancy may be found in mother or fetus or both. Untoward sequelae in the mother, when they occur, are generally the result of toxicity of the particular drug enhanced by the physiological alterations of pregnancy. An example of this type of reaction, to be considered in detail later, is that seen with the antibiotic tetracycline. Fetal ill-effects may be either of two types. Certain drugs, such as thalidomide, when administered during the critical period of organogenesis, may cause a morphologic abnormality in the developing embryo or fetus. The second type of fetal effect consists of some abnormality in physiology during fetal life or after birth and may be seen as the result of a drug, such as a long acting sulfonamide, given in late pregnancy.

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The present report consists of a review of some of the drugs which may have ill-effects in pregnancy and an attempt to develop some general principles regarding drug therapy in the pregnant woman.

It is first necessary to say something about the placenta since this organ represents the portal of entry for all agents reaching the fetus. The frequently-used term "placental barrier" should be deleted from our vocabulary; the placenta is not much of a barrier, at least to the agents under discussion. It is more like a sieve and indeed, in the case of some agents, such as ascorbic acid[1], it seems to behave like a pump, resulting in higher concentrations on the fetal side than on the maternal. While it is true that some drugs and chemicals, such as curare[2], do not traverse the placenta and others, such as insulin[3], are transported to only a limited degree, the general rule is that most drugs administered to a pregnant woman reach her fetus in therapeutic concentrations.

Antimicrobial Agents

The wide use of antimicrobial agents for various infectious diseases coincidental with pregnancy has led to recognition of ma-

ternal or fetal complications related to several drugs.

Tetracycline appears to be associated with adverse effects in both mother and fetus. Its principal fetal effect is a brownish or yellowish discoloration of deciduous teeth due to deposition of a tetracycline fluorescent complex. Observations in premature infants treated with tetracycline and experiments in pregnant rats[4] suggest that a similar effect in growing bone may result in abnormalities of skeletal growth. It should be noted that, from the fetal point of view, the critical period for tetracycline damage is the latter half of gestation, in contrast to most other agents which cause fetal ill-effects. The maternal complications seen with tetracycline administration are related to fatty infiltration of the liver, a histologic finding in many pregnant women receiving tetracycline[5]. A number of maternal deaths have occurred in patients given high doses of tetracycline intravenously for pyelonephritis of pregnancy. Though the mechanism is not precisely understood, it seems clear that the combination of pregnancy, diminished renal function, and tetracycline is potentially dangerous. For these reasons, tetracycline generally should be avoided in pregnancy, particularly in late pregnancy and in patients with possible renal disease. When used, the dose should not exceed one gram per day.

Sulfonamides readily cross the placenta and reach therapeutic concentrations in the fetus where they compete with bilirubin for binding sites on serum albumin[6]. Thus, the effect may be an increase of unconjugated bilirubin. This effect is most marked when long-acting sulfonamides are used. Hyperbilirubinemia constitutes no threat during intrauterine life because of placental clearance of bilirubin, but a newborn infant with high sulfonamide levels from previous maternal administration could conceivably be at risk for kernicterus. It is therefore recommended that long-acting sulfonamides be avoided in pregnancies in which there is likely to be impaired bilirubin metabolism in the newborn infant. Examples of such conditions are erythroblastosis fetalis and prematurity.

Chloramphenicol administered to premature infants appears to be associated with development of the "gray syndrome." However, there is no evidence to suggest that it has any ill-effects when it reaches the fetus after maternal administration. Bone marrow depression in pregnant women receiving chloramphenicol appears to be no more frequent than in non-pregnant patients.

Penicillin is present in fetal blood in therapeutic levels following maternal administration. There are no apparent ill-effects on either mother or fetus associated with its use in pregnancy.

Hormones and Related Drugs

Masculinization of the external genitalia of a female fetus with androgenic substances administered during pregnancy has been recognized for many years. With the advent of synthetic progestins and their recommended use by some in threatened or habitual abortion, a number of cases have been reported in which the prolonged use of oral progestins during pregnancy has been associated with clitoral enlargement and fusion of the labio-scrotal groove[7].

The use of corticosteroids in pregnancy has been subjected to considerable scrutiny because of the experimental production of cleft palate by administration of cortisone to rats in early pregancy. Careful review of human pregnancies in which cortisone was given during the time before palatal fusion is complete, however, has not substantiated an increased incidence of palatal lesions in such patients[8]. Moreover, there is no evidence, experimental or clinical, linking any of the cortisone analogs (hydrocortisone, prednisone, triancinolone, and dexamethasone) with congenial malformation in the fetus. The possibility of acute adrenal insufficiency in an infant born to a woman on long term corticosteroid therapy, although rarely reported, should be borne in mind.

Though there are a few if any adverse fetal effects of maternal thyroxine administration, probably because of limited placental permeability of the hormone, iodine has been implicated as a cause of congenital goiter and the prolonged use of iodine-containing substances during pregnancy is not recommended[9]. Congenital goiter has also been reported in infants whose mothers received thiouracil derivatives for hyperthyroidism during pregnancy.

Cancer Chemotherapy Drugs

Antimetabolites may exert profound fetal effects when administered during the period of organogenesis. Methotrexate given in early pregancy, for example, virtually always causes either abortion or serious fetal malformation[10]. Alkylating agents appear to be less teratogenic in humans, but congenial anomalies have occurred following their use. These therapeutic agents are used for maternal malignant diseases and are therefore rarely indicated. When such an indication exists, however, it usually takes priority over possible adverse fetal effects.

Anticoagulants

Heparin apparently does not cross the placenta and its use in pregnancy has not been associated with adverse effects on the fetus or newborn[11]. Coumadin derivatives, on the other hand, readily traverse the placenta and the incidence of fetal loss in coumadin-treated pregancy is approximately twice that of normal patients. It has been suggested that this increased loss is related to excessive dosage but some authors have reported fetal or neonatal death due to multiple hemorrhages which occurred in spite of careful control of maternal prothrombin levels[11].

The threat of postpartum hemorrhage in a patient who is therapeutically anticoagulated is not nearly as great as might be thought. Hemostasis in the uterus after delivery depends to a relatively minor degree on the coagulation mechanism. If excessive bleeding does occur, a patient anticoagulated with heparin has an advantage over one who has been taking coumadin because of the rapid reversibility of the former with protamine.

Tranquilizers

In view of the widespread use of psychopharmacologic agents in our culture, it is rather surprising that not more is known of their effects on reproduction. Reserpine administered shortly before delivery has been associated with a syndrome of nasal congestion, lethargy, and bradycardia in the newborn infant[12]. The phenothiazines, which have a definite incidence of liver toxicity in adults, have been exonerated with regard to accentuation of neonatal jaundice. Meclizine and similar agents have been reported to be associated in increased incidence of fetal malformation in laboratory animals but no such association in humans has been demonstrated.

Beyond these few observations, little is known. There is, however, a general feeling of conservatism in regard to using drugs of this type in pregnancy. Such conservatism is undoubtedly based on the fact that such drugs are seldom essential or lifesaving and, as such, is sound. It should not be forgotten that thalidomide was originally introduced for this type of indication.

Summary

With this admittedly brief review of the effects of some pharmacologic agents on mother and fetus, it is possible to summarize by drawing some general conclusions regarding the use of drugs in pregnancy.

Firstly, and most importantly, before administering any drug to a pregnant woman, one must consider very carefully the indication for therapy and the possible benefit to be derived. In deciding whether to treat a patient with threatened abortion with a synthetic progestin, for example, possible masculinization of a female fetus is really rather beside the point, in view of well-controlled studies[13] demonstrating no increased fetal salvage with progestational therapy in threatened or habitual abortion.

Secondly, in instances in which one drug is clearly indicated for treatment of a life or health-threatening condition, that agent should, in general, be used even though it may pose a threat to the fetus. For example, if the treatment of choice of thyrotoxicosis in a particular patient, who happened to be pregnant, were thought to be propylthiouracil, then this is the medication which should be employed.

Thirdly, in instances in which treatment is indicated but either of two equally efficacious agents may be used, the one having the last toxicity or suspension of toxicity should be selected. For example, anticoagulation for thrombophlebitis in pregnancy is better accomplished with heparin rather than coumadin, all other factors being equal, because of the lack of placental transfer of heparin and its ready reversibility.

Finally, in the absence of more specific data than are presently available, we must adopt a generally conservative approach to

the use of drugs in pregnancy. We must recognize, and we must convince our patients, that life is not, in fact, a "drug-deficiency state."

References

1. Manhan, C. P., and Eastman, N. J.: "The cevitamic acid content of fetal blood." Bull. John Hopkins Hosp. 62:478, 1938
2. Cohen, E. N., Paulson, W. J., Wall, J., and Elbert, B.: "Thiopental, curare and nitrous oxide anesthesia for cesarean section with studies on placental transmission." Surg. Gynec. and Obst. 97:456, 1953
3. Pitkin, R. M., and Reynolds, W. A.: Unpublished data.
4. Cohlan, S. Q., Bevelander, G., and Tiamsic, T.: "Growth inhibition of prematures receiving tetracycline." Am. J. Dis. Child. 105:453, 1963
5. Allen, E. S., and Brown, W. E.: "Hepatic toxicity of tetracycline in pregancy." Am. J. Obst. and Gynec. 95:12, 1966.
6. Odell, G. B.: "Studies in kernicterus. I. The protein binding of bilirubin." J. Clin. Invest. 38:823, 1959.
7. Wilkins, L.: "Masculinization of female fetus due to use of orally given progestins." J.A.M.A. 172:1028, 1960.
8. Bongiovani, A., and McPadden, A. J.: "Steroids during pregnancy and possible fetal consequences." Fertil. & Steril. 11:181, 1960.
9. Petty, C. S., and Dibenedetto, R. L.: "Goiter of the newborn." New England J. Med. 256:1103, 1957
10. Kistner, R. W.: "Hazards of obstetrical and gynecological drugs." Ohio M.J. 60:1125, 1964
11. Adamsons, K., and Joelson, I.: "The effects of pharmacologic agents upon the fetus and newborn." Am. J. Obst. & Gynec. 96:437, 1966.
12. Desmond, W. M., Rogers, S. F., Lindley, J. E. and Noyer, J. H.: "Management of toxemia of pregnancy with reserpine. II. The newborn infant." Obst. & Gynec. 10:140, 1957.
13. Goldzieker, J. A.: "Double-blind trial of a progestin in habitual abortion." J.A.M.A. 188:651, 1964.

School Immunization

As you are undoubtedly aware, the recent session of the Legislature passed bills, approved by the Governor, requiring immunization of all Illinois school children prior to entering kindergarten or first grade, and of every child first entering any public, private or parochial school in this State, against measles, poliomyelitis, diphtheria, pertussis, tetanus and smallpox. One of the bills (H.B. 1411) gave the Illinois Department of Public Health responsibility for promulgating rules and regulations requiring immunization of children. This statute also provides that the Director shall appoint an Immunization Advisory Committee consisting of seven members who shall advise and consult with the Department in the development of the rules and regulations to be promulgated under this Act.

In order that the medical society members may be fully informed in regard to the implementation of these bills, copies of the "Policy of the Illinois Department of Public Health Concerning Implementation of An Act to Amend Section 27-8 of the School Code" (H.B. 1410) and the companion bill (H.B. 1411) are available through the state or the county medical society. Copies of the informational releases prepared by the various agencies of State Government that are concerned with administration of the compulsory immunization laws, and with changes in the School Code related to physical examination of school children, (S.B. 954) are also available.

We have discussed the matter of who is permitted to give physical examinations and immunizations with the Office of the Superintendent of Public Instruction. While the literal interpretation of S.B. 954 may be construed to be that *both* physical examinations and immunizations can be done only by physicians licensed to practice medicine in all its branches, by practice in this State registered nurses do give immunizations at the authorization and instructions of the physician licensed to practice medicine in all its branches.

Franklin D. Yoder, M.D.
Director of Public Health

Hernia Of The Esophageal Hiatus In Infants

By Mark M. Ravitch, M.D., Marc I. Rowe, M.D.,
and David C. Halperin, M.D./Chicago

Hernia of the esophageal hiatus in infants is frequently an obscure and troubling phenomenon, hazardous to the growth and development of the child and often extremely difficult to diagnose. For some years it has been commonplace to say that this condition has been more commonly observed in England where larger series have been accumulated than in this country. As might be expected, closer attention to the symptomatology involved, and sophisticated diagnostic studies have resulted, here as well, in more frequent diagnosis with consequent relief to the patients involved.

The vast majority of infants, as every mother knows, burp and regurgitate. In the infant with a sliding hernia of the esophageal hiatus and resultant incompetence of the sphincter mechanism of the esophago-cardiac junction this occurs to so marked a degree that the infant seems actually to vomit, is unable to retain enough to gain weight properly and may actually lose weight seriously. If the condition is neglected, the prolonged exposure of the esophagus to the acid gastric juice results in esophagitis which may be manifested in the infant by occasional blood in the vomitus and presently by the development of an esophageal stricture.

As the stricture begins to develop it may offer enough obstruction to regurgitation so that the child deceptively enough may seem improved for a period of time. Presently, however, the stricture becomes so dense as to interfere with swallowing and one is then faced with one of the most serious problems of esophageal surgery in infancy. Such strictures may respond to dilatation and it may then be possible to operate successfully upon the esophageal hiatus hernia. However, in general, once a stricture develops, one is faced with a situation in which in the first place, the stricture does not yield very well to dilatation and in the second, the reconstruction of the esophageal hiatus is no longer possible because the esophagus, contracted, scarred and adherent to the mediastinum, cannot be successfully brought down to allow the stomach to lie entirely in the abdomen. The frequent result is that one must resort in such unfortunate children to the major expedient of resecting the esophago-gastric junction with the stricture, and interposing a segment of bowel, usually colon. While this is a satisfactory enough procedure, compatible with a long and normal existence and unimpaired deglutition, it still involves a very large operative procedure and is something which one would wish to avoid.

The diagnosis of esophageal hiatus hernia is entirely dependent upon careful and repeated roentgenography. One cannot count on being able to demonstrate an esophageal hiatus hernia by a single barium swallow and the following report illustrates the difficulties which may be involved in making the diagnosis even when it is suspected.







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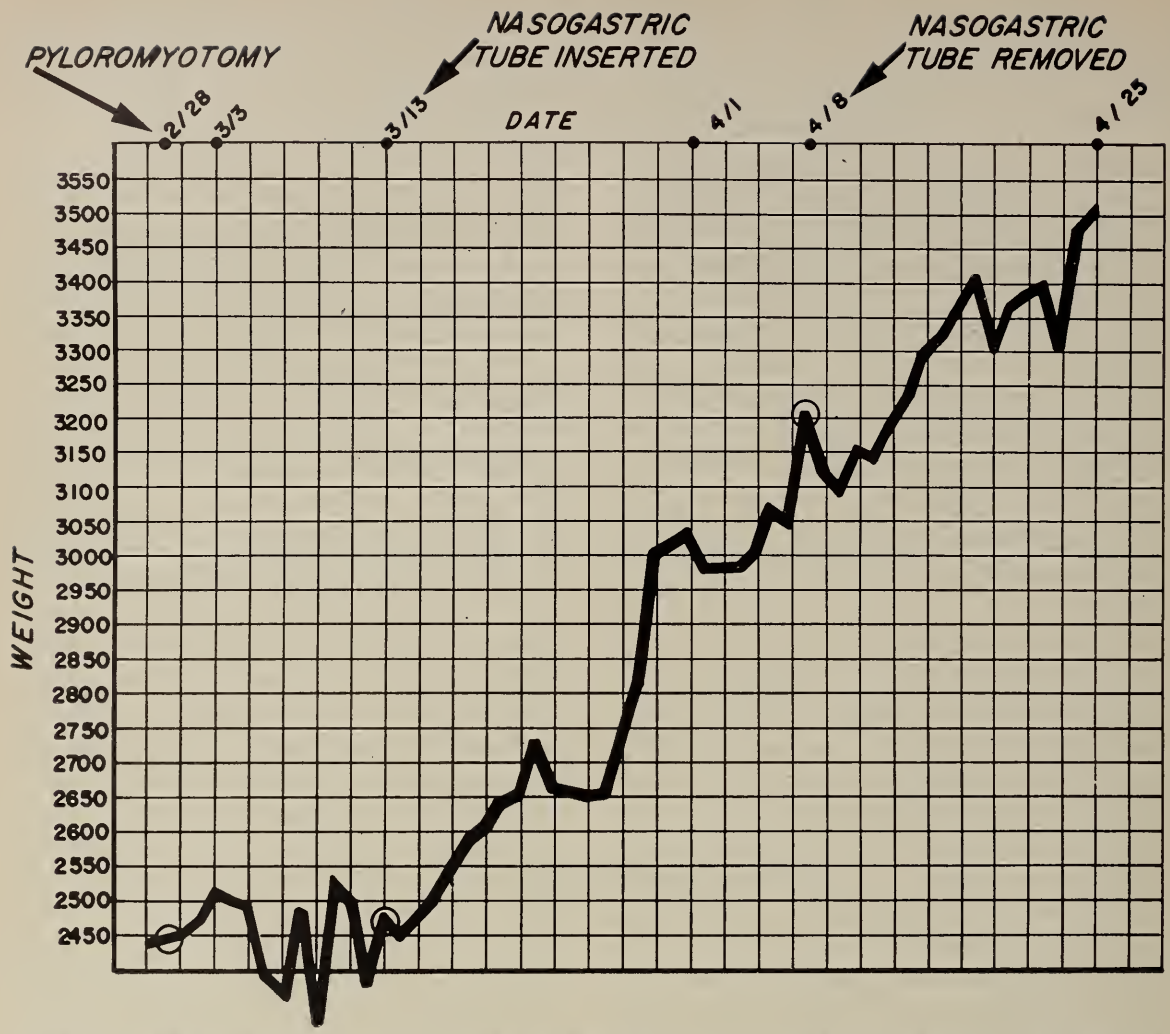


Fig. 1. Weight chart of infant 4 weeks old, admitted for vomiting and failure to thrive. The pyloric tumor was palpable. A hiatus hernia was suspected but not demonstrated radiologically and a pyloromyotomy was performed. The child failed to gain. Cinefluorography was unsuccessful in demonstrating any hiatus hernia. The child was put in an esophageal box and fed with an indwelling nasogastric tube. Weight gain was progressive. The third radiologic examination now demonstrated the hiatus hernia (Figures 2a and b). After almost four weeks of nasogastric feedings, the tube was removed and the child continued to gain weight, being maintained in the esophageal box. He has had no difficulty since.

Case History

A baby (A. McG., History No. 94 26 67) was admitted to the Wyler Children's Hospital of the University of Chicago with the diagnosis of pyloric stenosis on the basis of one week of violent vomiting. It had, indeed, been noted that the child had vomited for the three preceding weeks of its life, although the vomiting had not been so dramatic. A small pyloric tumor was felt by a number of seasoned observers so that the diagnosis of congenital hypertrophic pyloric stenosis was not in doubt. However, in view of the fact that the tumor was a small one, that there is an incidence of something like 10 per cent of congenital hypertrophic pyloric stenosis in association with hiatal hernias, and because the child had in fact vomited for the first three weeks of its life before the severe projectile vomiting of the fourth week, a barium swallow was undertaken on the morning of the day on which the child had already been posted for operation. This roentgen study failed to show a hiatus hernia. At operation a typical rubbery edematous pyloric tumor was found and the usual Fredet Ramstedt procedure performed. After operation the child continued to vomit precisely as he had before and another radiographic study was undertaken, this one with the aid of cinefluoroscopy. Once more no hiatus hernia was seen and the stomach emptied well. The child's progressive weight loss was beginning to cause concern (Fig. 1). The child seemed constantly hungry but

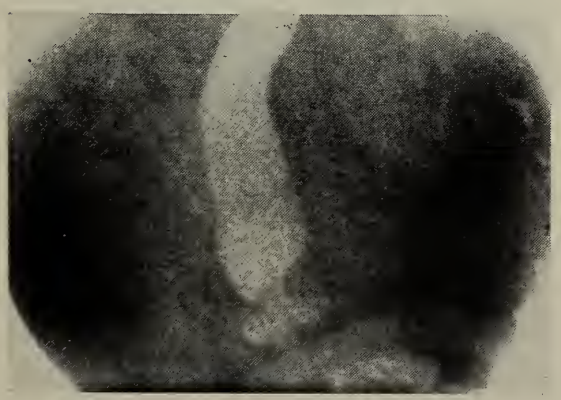
vomited most of what it took. There was no bile in the vomitus. It finally seemed best to pass a nasogastric tube and to instill frequent small feedings, keeping the child constantly upright. With this measure the weight loss stopped and the weight began to increase and now another cinefluoroscopic study was undertaken. This time there was shown an unequivocal herniation of the stomach through the hiatus well up into the chest (Figs. 2a and b). This had not been seen on either the first or the second study and in the second study, the first cinefluoroscopic study, the esophagus had seemed to show only abnormal and poor motility.

On this basis the child was continued for one week more with gavage, being constantly maintained in the erect position in a little plastic "esophageal chair."

Most esophageal hiatal hernias in infants will respond to the maintenance day and night of the erect position and operation will usually not be necessary. In very large hiatus hernias, in neglected ones in which esophagitis has become manifest, or in occasional patients who do not respond within a reasonable period of time to the constant maintenance of the erect position, operation should be undertaken.

What is the fate of the hiatal hernia in the child whose symptoms recede on treatment in the erect position? Certainly the symptoms do not recur and the children have seemed well. An ususual study is that of Roviralta[2] who was able to trace eleven children 5 to 20 years after nonoperative treatment for hiatus hernia. He found that their symptoms had never recurred and that barium swallow years later showed either significantly less herniation or no hiatus hernia at all. This is perhaps analogous to the situation in the treatment of rectal prolapse in infants. Rectal prolapses in infants are as true prolapses as those in adults but instead of being progressive and inevitably requiring an operation, the vast majority of them yield to reposition and strapping of the buttock and after one, two, or three recurrences usually remain successfully and permanently reduced and lead to no further trouble.

In the children in the three categories described, those with large hernias, those with incipient esophagitis, and those failing to respond symptomatically to maintenance in the erect position, operation is undertaken. This is exemplified by patient number 2. This child, at the age of eight months, weighed 4.6 kg. Her mother stated that during the child's entire life there had never been a day when she had not vomited all of one feeding and never a feeding of which she had not returned a considerable portion. Otherwise the child was well



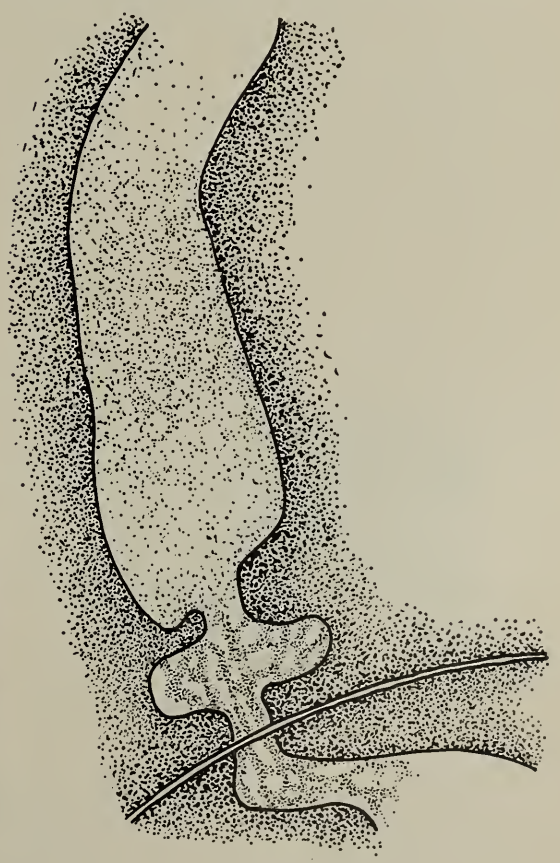


Fig. 2. *a.* *b.*

a. Roentgenogram.

b. Artist's sketch of the roentgenogram taken from a single cine frame. There is an obvious gastric pouch above the diaphragm. As obvious as this was in this examination, it was completely missed in two previous examinations and was not seen in a portion of this examination.

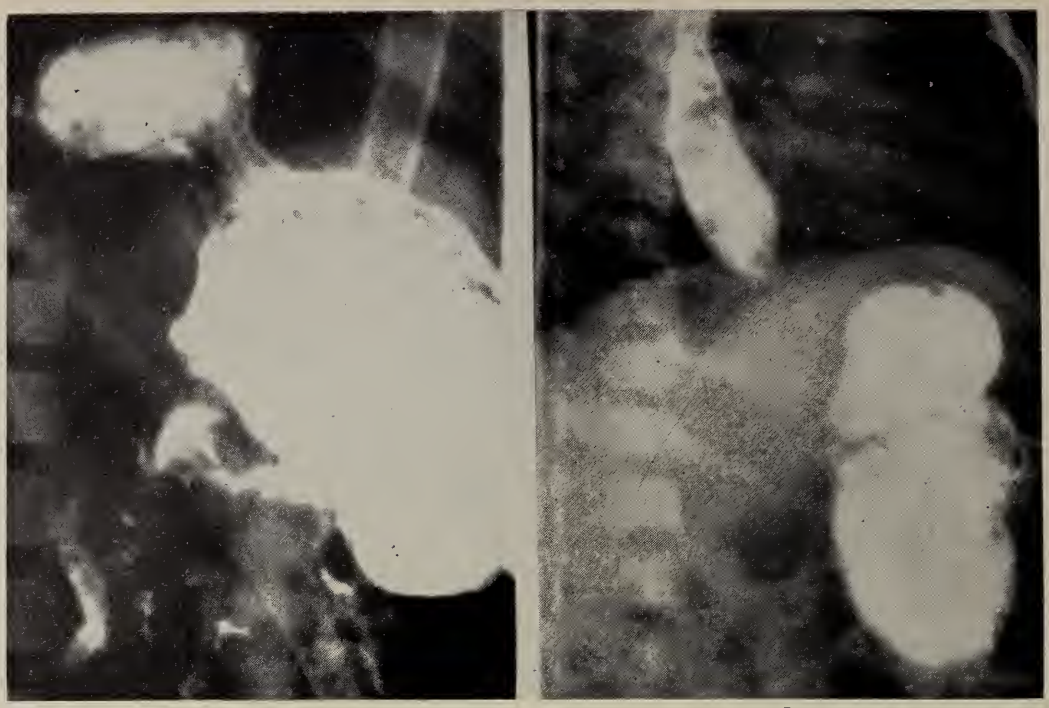


Fig. 3. *a.* *b.*

Hernia in 8 month old infant who had vomited part of every feeding from birth and vomited at least all of one feeding each day since birth and was admitted with malnutrition, underdevelopment and the appearance of blood in the vomitus.

a.) Preoperative roentgengram showing large gastric sliding hernia (left).

b.) Roentgengram following Nissen Fundoplication showing correction of the hernia and subdiaphragmatic length of the esophagus.

and she ate hungrily. At the time she was admitted to the hospital there had begun to be blood mixed with the vomitus. Again it required two barium swallows to demonstrate the hiatus hernia but it was clearly demonstrated as seen in Fig. 3. We were faced with a severely under-nourished child, one in whom the appearance of blood in the vomitus suggested beginning esophagitis, and it therefore seemed wise to proceed at once with the operation.

A left subcostal incision was made. When the stomach was drawn down, an esophageal hiatus was found which accommodated

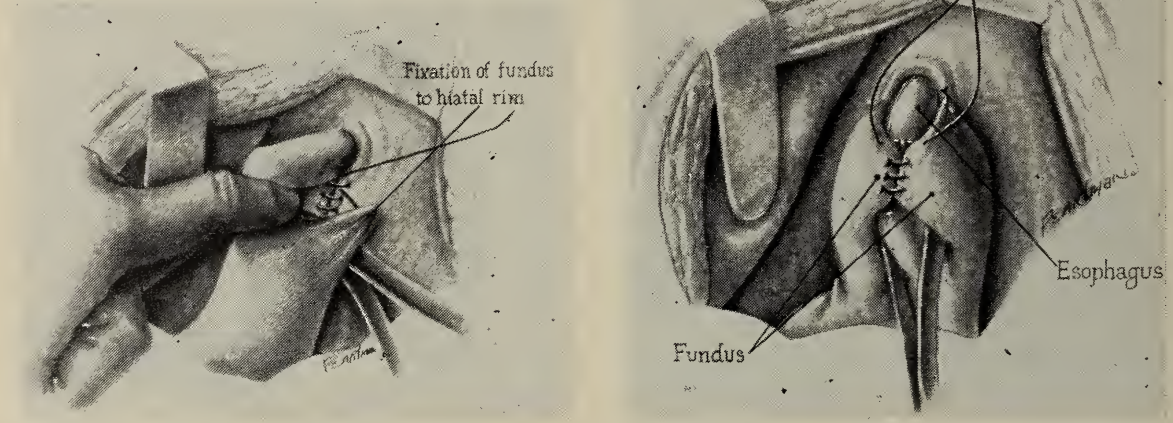


FIG. 4. *a.* *b.*

Operative repair of hiatus hernia in an infant.

a. Three sutures have been placed to approximate the crura behind the esophagus which is seen with a large rubber sound in it. The cardia is now tacked up to the edge of the hiatus.

b. A penrose tubing is shown around the esophagus while the fundus has been pulled up around the esophagus and sutured to itself and to the esophagus.

The operation is readily performed through the abdomen and we prefer a subcostal incision. The effect of the operation is: 1) to re-create the re-entrant of His, 2) to produce a valve-like projection of the esophagus into the stomach, and 3) to produce a mass of tissue which must effectively work against re-herniation, quite apart from the sutures tightening the hiatus.

three of the operator's fingers in addition to a number 34 stomach tube which had been passed through the mouth, a large hernia. As is usual with hiatal hernias, there was not a significant hernial sac. A Nissen repair was performed as indicated on the accompanying illustration (Fig. 4), and a gastrostomy tube inserted.

The child has not vomited since operation. The gastrostomy tube was removed in a few days without ever having been used.

From the standpoint of operative repair, we feel that in addition to the standard closure of the hiatus it is important to tack the fundus high in order to re-create the re-entrant angle of His. We find the Nissen fundoplasty a very useful technique for maintaining this angle and accentuating its valve-like function as well as for creating a bulk of tissue which will not easily ascend through the hiatal orifice.

Summary

Hernia of the hiatal orifice in infants is manifested by vomiting, often suggestive of pyloric stenosis and sometimes mistaken for it. The diagnosis may require repeated and careful fluoroscopy particularly with a cine apparatus. In most patients the treatment is postural, maintaining the children day and night in erect position. The evidence is that most children will respond to this treatment and that the hernia will recede or disappear.

In children who do not respond to this treatment, or who demonstrate beginning esophagitis, or who have very large hernias, operation is advised and our present preference is for the Nissen fundoplasty.

References

1. Nissen R., The Treatment of Hiatal Hernia and Esophageal Reflux by Fundoplication. In Hernia, Nyhus, L. M., and Harkins, H. N., Philadelphia, J. B. Lippincott, 1964.
2. Roviralta, E., Historia Natural de las Hernias Hiatales, Rev. Clinical Exp., 96:235-244, 1965.
3. Waterson, D., in Pediatric Surgery, C. D. Benson, W. T. Mustard, M. M. Ravitch, K. J. Welch, and W. H. Snyder, Chicago, Yearbook Medical Publishers, 1962.

Bundle Branch Studies Reported

In 36 cases the atrioventricular node and main bundle were normal, but lesions were found in both bundle branches. In only six cases in this group was the lesion due to ischemia, and these old septal myocardial infarcts extended into the conducting tissue. The commonest lesion, found in 19 cases, was a loss of conducting fibers and their replacement by fibrous tissue restricted to the original outlines of the two bundle branches. In all these cases the myocardium adjacent to the bundle was normal, though some showed small focal scars elsewhere in the myocardium. Detailed study of the coronary arteries in these 19 cases revealed no significant occlusive disease to produce ischemia. In the remaining patients the bundle-branch lesions were due to cardiomyopathy in seven, rheumatic myocarditis in two, and active non-specific myocarditis in two. Findings in the 14 cases of heart-block associated with acute myocardial infarction were quite different and of importance in assessing the role of coronary-artery disease in chronic heart-block. Recent posteroseptal infarcts were found in 13 cases, with occlusion of the right coronary artery in nine and the left circumflex artery in four: the other case had a massive anteroseptal infarct, with occlusion of the anterior descending coronary artery. The findings in the conducting system were of particular interest. Two cases showed necrosis of both bundle branches, and, had the patients survived, the lesions would probably have been permanent. In four cases no lesion of conducting tissue was found, and in the remainder only partial lesions were present: in all these patients sinus rhythm would probably have been restored had they survived. These findings support the clinical observation that permanent heart-block is an uncommon sequel of myocardial infarction. The conducting systems of the control hearts were intact, though there was some fibrosis of the atrioventricular node and bundle with increasing age. Etiology of Complete Heart-Block. (Leading Article) The Lancet (Apr. 6) 1968, pgs. 731-732.



EDUCATION IN COMMUNITY MEDICINE AT THE UNIVERSITY OF CHICAGO

The University of Chicago's major involvement in community medicine, at the present time, centers about the establishment of a Comprehensive Care Center for children in the Woodlawn community.

Woodlawn is a neighborhood just south of the University which represents a microcosm of the kinds of problems found in a disadvantaged urban neighborhood. Overcrowding, absentee landlords, and gangs are difficulties with which Woodlawn has to deal. The infant mortality rate, that critical index of how medically disadvantaged an area is, is 54 per 1000. Woodlawn also has strengths, chief among which are its organizations and its wealth of concerned citizens, who are willing and capable of helping to work out solutions to the area's problems.

Working in conjunction with the neighborhood, through an Advisory Board, the University of Chicago has established the Woodlawn Child Health Center for the indigent children of Woodlawn. The Clinic is financed through the United States Children's Bureau, and is an integral part of an over-all city program, directed by the state and city Boards of Health.

The aim of this Clinic is to provide care for acute and chronic illnesses, diagnostic consultation, preventive medicine, and health education. This is to be done with an attitude and in an atmosphere that will not jeopardize the dignity and self-esteem of those served. The underlying premise is that good health is a right and not a privilege.

The Center is operated as a referral center for such agencies as the Board of Health, Infant Welfare Stations, the schools, both public and parochial, and Head Start, as well as a self-referral clinic for the community. The location is in the main business district of the neighborhood.

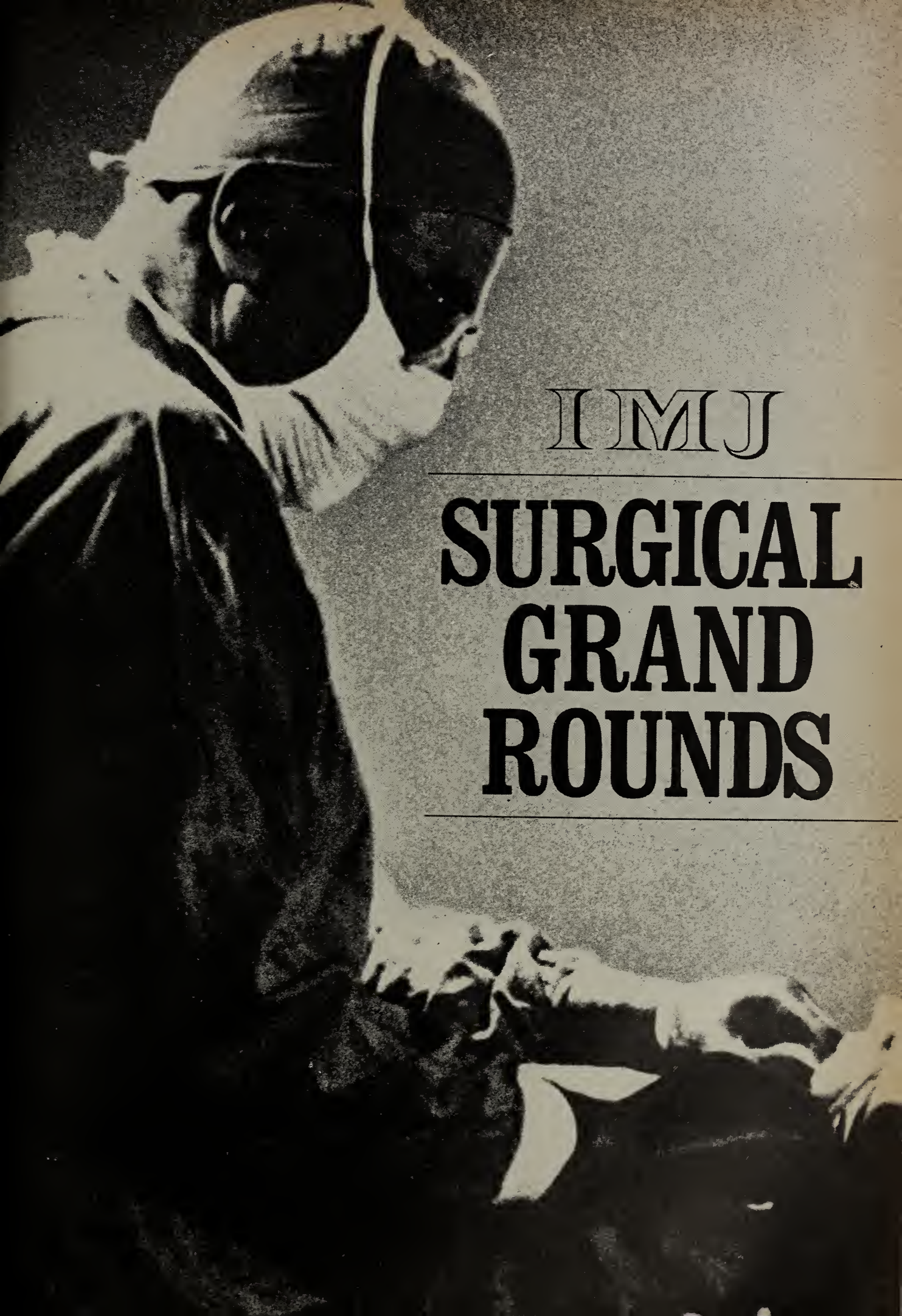
The purpose of this is really twofold, bringing the services to the people and, on the other hand, helping those who provide the service to become more aware of the problems they are trying to solve.

In our efforts to provide education in community medicine we have formally established an elective period in the senior year during which the student can work alongside and under the supervision of the attending pediatricians. We also provide a rotation through the Center as an integral part of the residency program in pediatrics.

Resident physicians in other specialties also become involved by providing consultation services to patients. Our educational aims are multiple. We hope, of course, to provide our students and house staff with an abundance of clinical experience. This is in keeping with the traditional aim of medical education—the development of a highly competent physician.

We are also highly interested in setting

(Continued on page 330)



IMJ

SURGICAL GRAND ROUNDS

Blunt Abdominal Trauma

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on January 20, 1968.

Case Presentation:

Dr. William Schiller: The patient, a 41 year old Negro male, struck an abutment while driving intoxicated. The steering wheel struck his upper abdomen. He was taken to another hospital where he was found to have a blood pressure of 70/50. He was transferred to the Veterans Administration Research Hospital five hours after the accident. Past history revealed that he had had a left thoracoplasty for tuberculosis 17 years previously. On physical examination in the admitting room: blood pressure 60/40, pulse weak and thready. Physical examination: marked tenderness in the epigastrium with rigidity in the right upper quadrant: bowel sounds were hypoactive. His hematocrit was 40 and white blood cell count was 11,000. The remainder of his laboratory findings were normal. After infusing two liters of lactated Ringer's solution the patient's vital signs became stable. X-rays of the chest and abdomen were obtained.

Dr. Abram Cannon: The film of the chest showed evidence of the previous thoracoplasty. The abdomen films were non-specific. There was air in the stomach and scattered through the bowel. Free air was not seen under the diaphragm and fractures of ribs were absent.

Dr. Schiller: The patient was operated upon within two hours of admission. The abdomen was opened through a left paramedian incision. Immediately upon entering the peritoneal cavity blood was encountered. Approximately a liter of blood was aspirated. Exploration of the upper abdomen revealed that the falciform ligament had been avulsed from the liver. Lateral to this there was a linear fracture on the superior or diaphragmatic surface of the liver, which extended to the left lobe of the liver. It was not bleeding actively. The remainder of the peritoneal cavity was explored for evidence of other injuries. The common duct was normal. A Kocher maneuver demonstrated that the head of the pancreas and duodenum were unharmed. The lesser peritoneal was opened and inspection of the remainder of the duodenum and pancreas failed to reveal any other injury.

During this period of exploration further bleeding from the liver had not occurred. The laceration was linear and was well approximated without sutures. Therefore, through separate stab wounds, three cigarette drains were brought out the left side with two of the cigarette drains over the dome of the liver and one into the left gutter. Three additional drains were placed through the right side into the foramen of Winslow and into the intrahepatic fossa. Postoperatively some serosanguinous fluid has appeared from these drain sites. He has made an uneventful recovery six days after operation.

Dr. Julius Conn: This man illustrates many of the problems encountered in treating blunt abdominal trauma. The delay from time of injury to the time of operation was approximately seven hours, which is in keeping with reports from most centers. Nonpenetrating wounds of the liver account for from 10 to 30 per cent of all

liver injuries.

The mortality rate varies directly with the length of time from injury to diagnosis. Therefore, delay in diagnosis and treatment is a critical factor. Another highly significant factor is the presence of associated injuries. The reported mortality rate for a single injury of the liver varies from 5 to 10 per cent, depending on the extent of injury to the liver. When there is injury to the liver and one other organ the mortality rate rises to approximately 25 per cent. When two other organs are injured as well as the liver a mortality rate of 40 to 50 per cent is encountered. Approximately one-third of these people will have associated head injuries. Analysis of pedestrian and automobile fatalities has shown rupture of the liver to be the most common abdominal injury. It has been estimated that one-third of the victims are dead on arrival at the hospital, one-third die within six hours of the accident, and one-third will survive.

The diagnosis of intraabdominal injury in this patient was not complex. He had obvious signs of peritoneal irritation so further studies, such as a peritoneal tap or arteriography were not required. At least three-fourths of patients with a liver injury will develop shock. In addition to blood loss, these patients sequester large amounts of fluid secondary to the bile leakage plus the local tissue trauma itself. Leukocytosis is frequently present.

The patient presented today was operated upon with a minimum of delay. Methods of treatment for these injuries have varied, but the control of hemorrhage and adequate surgical drainage are of prime importance. If the bleeding is massive a clamp on the portal triad will control bleeding temporarily. Under these circumstances one has about 15 minutes of safe ischemia time at normal body temperature. However if the patient's temperature is lowered to about 32°C. occlusion can be prolonged for approximately 30 minutes. Therefore, these patients should be placed on a hypothermia blanket prior to operation if liver injury is suspected. Resection is becoming more frequent with the blunt type of injury. Most of these require sublobular resections. T-tube drainage has been advocated since patients who have sustained injuries to the liver will frequently have an elevation of the pressure within the biliary tree. Drainage of the common duct with the T-tube or catheter lowers the intraductal pressure and facilitates sealing of lacerated bile ducts. It did not seem necessary in this case to drain the common duct because the laceration seemed to be relatively superficial.

The laceration was not closed in this patient. Tight closure associated with continued bleeding into the parenchyma of the liver will result in a large hematoma which may fracture the liver or else become infected. It is better in a superficial hepatic laceration to simply drain the area widely.

There has been considerable interest in the use of the cyanoacrylate tissue adhesives on liver lacerations. These sprays are undergoing extensive study. Application of the spray to the surface of the liver seals open vessels and ducts. Another new tool that may become available in the management of liver injuries is the use of cryogenic apparatus. These are also being evaluated in controlling massive bleeding from the raw surfaces of the liver.

Dr. James Hines: Acrylic sprays are being tested for many other uses, including incisions for laparotomy. There is an attempt being made now to develop these sprays so one can just open the abdomen or chest and simply spray the surface to obtain hemostasis. Currently their use has been confined to intraabdominal or intrathoracic injuries where there were large areas of oozing.

Dr. John Beal: This patient had been subjected to thoracoplasty in the past and now suffered a serious abdominal injury which required operation and anesthesia. Dr. Eckenhoff, do such patients offer any special problems?

Dr. James Eckenhoff: I would not have been particularly concerned about the thoracoplasty in this individual because it was performed a long time ago and he had accommodated well to it. There is a real possibility that some one might become too worried about the thoracoplasty, and as a consequence attempt to anesthetize the man too fast and too deeply. In the presence of shock deep anesthesia results in loss of compensatory circulatory reflexes and a sudden demise may occur under these circumstances. A reasonably slow induction of anesthesia with the establishment of an airway with an endotracheal tube is proper. ■



THE DOCTOR'S LIBRARY

Obstetric Analgesia and Anesthesia. By Charles E. Flowers Jr., M.D. Hoeber Medical Division, Harper and Row, Publishers, New York, 1967.

This book is written by an obstetrician for obstetricians. The author has had a long, active and fruitful interest in the problems of obstetrical anesthesia, culminating in his service as Chairman of the American College of Obstetrics and Gynecology Committee on Obstetrical Analgesia and Anesthesia in 1965-66. In spite of this, or perhaps because of it, Dr. Flowers' approach in this textbook to anesthesia in the obstetrical patient largely excludes the anesthesiologist. He chooses to stress the problems of the past instead of providing the instruction that will lead to solutions in the future. For example, the chapter on "Anesthesia Coverage and Maternal Mortality" explores, in detail, the lack of obstetrical anesthesia coverage in North Carolina, but one is unable to find in this book an adequate discussion of methods of maintaining airway patency or of treating the patient who has vomited and aspirated stomach contents, although this is stated to be the greatest hazard in obstetrics. One must, of course, disagree with this latter statement of the author. The greatest hazard in obstetrics, as in all of medicine, is the physician who does not understand the limits of his own capabilities.

Providing a cookbook approach to the superficialities of anesthetic administration, without providing a sound basis in the principles of anesthesia will lead to still another generation of obstetricians who fail to comprehend their own inadequacy in this field. Dr. Flowers' statement, for example, that ethylene should never be administered in a closed system because of the explosive hazard shows a lack of insight into primary anesthetic principles—cyclopropane is often given in a closed system just because it is explosive and a closed system confines the explosive mixture. Ethylene is not given in a closed system, but for other reasons. The recommendation to use thiopental as a five percent solution, a practice which may have been acceptable twenty years ago, would be criticized by most practicing anesthesiologists as being unduly hazardous.

The failure to discuss the pros and cons of spontaneous, assisted and controlled ventilation—a subject of current interest among obstetric anesthetists—clearly demonstrates a lack of anesthetic orientation in this text. The index entry for "respiration, control" refers to breathing exercises to be used by the patient to facilitate labor, an obvious reflection of the obstetric orientation of the author. When the author discusses systemic analgesia and amnesia for labor and delivery, or when he discusses techniques of conduction anesthesia the principles which he propounds are firmly based. On the other hand, the chapters which discuss inhalation anesthesia, intravenous anesthesia, the use of muscle relaxants or which concern themselves with the general principles of anesthestic practice treat of their subject in the most superficial way. The practice of medicine has progressed beyond the point where diagrammatic representations of flow.meter settings are useful to teach the neophyte to administer anesthesia. He must be taught the physiology and pharmacology of anesthesia as well as the mechanics. This book fails in this respect and therefore has little to recommend it as a text for learning obstetrical anesthesia. It may be useful to the obstetrician learning the principles of pain relief during labor.

Edward A. Brunner, M.D., Ph.D.



122 Years of Aesculapian

By G. T. Mitchell, M.D./Marshall, and
E. P. Johnson, M.D./Casey

The names of doctors appear prominently among those who forged westward in the early exploration of the vast unknown beyond the Allegheny mountains.

In March, 1773, Dr. John Briscoe, with five large canoes and 15 men under his command, put ashore at a fine bottomland opposite a nearly mile-long island close to the Ohio shore just six miles above the Little Konawha River (the present site of Boaz, W. Va.). It is stated that "John Briscoe was not only an adventurer and land speculator: he was a good doctor as well."[1] In April, 1774, the Earl of Dunsmore, governor of New York and the Virginia Colonies, ordered Capt. John Connelly, a physician by profession, to raise an army of 3,000 men to go against the Scioto River Indians.[2]

And so it was in Southern Illinois. The medical profession was well represented among the white men first to enter this region. One of the earliest to come was Dr. George Fisher. His lonely grave lies near the intersection of Illinois highways 3 and 155 at the village of Ruma. Dr. Fisher built a home and opened a farm in 1806. It was here that he built a hospital, the first in Illinois, in 1808. He was a member of the first House of Representatives of the Indiana Territory, Speaker of the House in the first and third Illinois Territorial Assemblies (1812-1814, 1816-1818) and a member of the First Illinois Constitutional Convention, 1818.[3]

Pioneer Life Described

The life of a pioneer doctor in Illinois was a vigorous and lonely one. There were no good highways to travel. It was necessary to walk or to travel horseback, following narrow trails through the woods or across the prairies. No bridges existed and crossing the streams was a most hazardous procedure at times, especially when the spring floods came. The waters would come rushing downstream and out into the bottom lands and many a helpless rider was swept from his horse to his death, or, if fortune was with him, he at last dragged himself up on the bank, soaked through with the icy water.

House visits were the custom, since it was most difficult to transport the patient to the doctor; he often was away from home for many days, being sent from one lonely cabin to another to minister to the sick and injured. His few instruments and medications were carried in a small bag strapped to his saddlebags. The pioneer doctor had no stethoscope, no thermometer, no sphygmomanometer, no hypodermic. Laboratory procedures were unknown. His eyes, his ears, his sensitive fingers were his diagnostic tools, and these he learned to use to a degree of proficiency unknown today. Rare was the doctor of those times who had the advantage of a classical course in medicine; most of them had taken training for a year under an old preceptor and then a

four month course of lectures in some medical school.

The pioneer doctor was daily faced with the innumerable demands of medicine—usually alone, as his colleagues were far away and consultations not easily secured. No telephones, no medical journals, no staff meetings existed to link him with his fellows. Decisions made, right or wrong, were the responsibility of but one man. The pioneer doctor longed for the opportunity to talk to a colleague, to consult, and to swap information. It was this sort of yearning which led to the formation of the earliest medical society west of the Alleghany mountains. This society, "The Aesculapian Society of the Wabash Valley," was organized in Lawrenceville in 1846 and is still active.* The story of the formation of the society can best be told we believe by the President's address entitled 'Evolution of the Aesculapian, delivered by Dr. Charles B. Johnson of Champaign on Oct. 31, 1907, during the Society's Sixty-First Annual Meeting at Paris.[4]

Some Experiences

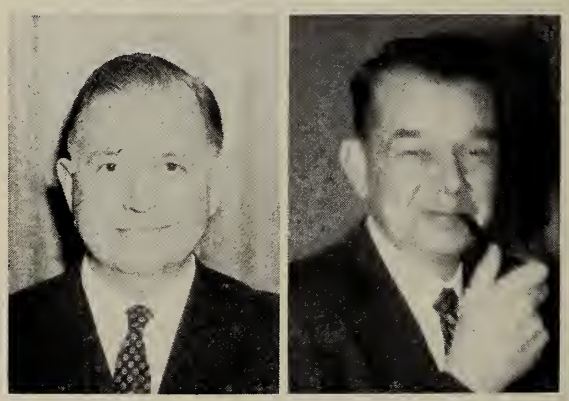
"Something like two generations ago a certain doctor who had his biding place not far distant from the Wabash River, was giving his days and no inconsiderable part of his nights to the manifold and laborious duties of a large country practice. Naturally the greater part of this man's work pertained to internal medicine. Nevertheless, he was no mean obstetrician, had some skill as a surgeon and was, moreover, something of a gynecologist. This last, however, without knowing it. I speak advisedly when I say 'without knowing it,' for in that period the word gynecologist had yet to be coined. . . . "

"At this period our Wabash Valley doctor was in the prime of life and busy making the rounds among his patients, scattered as they were, over a large extent of country. . . . It was a virgin country, as wild and as nearly over-run by rank vegetation as a warm sunshine, a quickening rain-fall and a responsive soil could make it. . . . "

"Perhaps a very brief recountal of some of this pioneer doctor's experiences would not prove wholly uninteresting: Early one morning in mid-winter a call came to go a long distance and see a man who was thought to have 'winter fever', or as we say today, pneumonia. Promptly the doctor mounted his horse and with his well-filled saddle bags, started his long journey. It was one of those disagreeable winter days when the ground was neither solid enough to hold the horse on its surface, nor thawed sufficiently to admit of the animal's feet with certainty touching bottom. But tedious as was the way, a reasonable degree of progress was made 'till a creek was reached which had to be forded, a most difficult task, as a sheet of ice reached out several feet from either bank and this the faithful horse had to break through at every step. Finally the footing proved so uncertain that he floundered and fell, but in the end regained his feet with no greater harm than an ice-cold bath to the rider."

An Urgent Call

"As the nearest house was miles away, there was nothing for the doctor to do but ride as hurriedly as he could to his destination. When he arrived there the condition of the sick man was found to be vastly more comfortable than that of his medical advisor. Faithful to what he es-



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*The society was chartered in 1847 as the "Lawrenceville Aesculapian Medical Society." In 1894, the name was changed to the "Aesculapian Society of the Wabash Valley" since it had long served a wide area of both Illinois and Indiana, on both sides of the Wabash River.

teemed his duty, however, the physician at once proceeded to minister to the patient's wants and put his own needs aside for the time being. But while he was yet at the bedside a messenger, pale with excitement, came for him to go to a cabin a mile distant and see a man who was thought to be bleeding to death. The call seemed to admit of no delay; consequently, our hard-worked doctor, though wet, cold and hungry, again got in the saddle and made his way fast as his horse could carry him to the place designated and where was found a man who had been caught under a falling tree and in consequence, sustained a compound fracture of the femur involving one of his knee-joints; an injury which in that day called for immediate amputation."

"The only instrument in the doctor's possession was a thumb lance for bleeding, an operation which two generations ago was practiced on substantially every second patient. Fortunately, however, our Wabash Valley doctor, like most country practioners, was resourceful and upon searching the premises, finally found at his service a sharp butcher knife, a hand saw, some strong linen thread, several large sewing needles, a supply of old clean muslin and a tea-kettle of hot water."

"Assisted by the more heroic among the neighbors, the patient, after being properly tied, bound and strapped to a table, submitted as best he could to the tortures of an amputation of the femur at the junction of the middle and lower thirds. Too bad, some one will say, that the operator did not have an anesthetic at his command. Yes, it was too bad. But in this particular case our pioneer doctor was as well off as the most advanced and progressive surgeon in New York or London as the discovery of practical anesthesia was as yet more than a year in the future. Crude and painful as was the operation, the man in the end made a good recovery, though it goes without saying that the healing process was accompanied with a free discharge of what the older surgeons called 'laudable' pus. . . ."

"But fortunately for this pioneer doctor's comfort and peace of mind, the roads were not always so bad, the cases not always so critical . . . as on this strenuous winter day. . . . "

"Towards noon one mid-summer day, with his horse in a lather of sweat, a man rode up to the physician's gate and said the services of a doctor were urgently needed some miles in the country at the farmhouse of one Joel Strong, whose youngest child was thought to be dying of spasms. To throw a saddle on his fastest horse and ride rapidly to the relief of the little sufferer was only carrying out what had become second nature in the life of this busy country practitioner."

Self-Treatment Obviates Need for Physician

"In due time the farmhouse was reached and at its front gate stood Joel Strong. His face, instead of wearing the expected troubled look, lighted up with a smile as he said: 'Well, Doc, guess the old wimmin's 'bout got your patient cured, by givin' him a puke and puttin' him in hot water, and when I come out a minit ago he was sittin' up and seemed as pert as could be. But say! a young one like that can be laffin' one minit and dyin' the next, so you go right in and see what he needs.' "

"Upon examination the condition of the little patient was found so favorable that some directions relative to diet and the use of a little compound spirits of Lavender met every indication in the case."†

"Upon one occasion this pioneer doctor was called upon to assist a physician whose field of practice adjoined his own. It was a difficult labor case. In due time the patient was relieved, but meanwhile the night had so far advanced that the medical attendants decided to remain 'till morning. They were thus given opportunity for becoming better acquainted and passed the time so pleasantly, exchanging experiences,

†Joel Strong was a thrifty pioneer and had the reputation among the neighbors of being a 'good liver' and among the women folks was known as a 'good provider.' He lived in a large double log house with an ample roofed-in and floored openway between the two rooms, where was spread the dinner table to which the doctor was invited and at which with the family he seated himself while the host and hostess were profuse in their apologies for having so little to offer their guest. . . . This little, with which the table was spread, consisted in part of fresh beef, fresh pork, venison, prairie chicken, wild turkey, fried chicken, fried eggs, broiled ham, Irish potatoes, sweet potatoes, turnips, snapbeans, butter beans, onions, cabbage, roasting-ears, egg bread, corn pones, wheat bread, biscuits, fritters, buck-wheat cakes, stewed peaches, stewed apples, stewed tomatoes, stewed pumpkin, baked squash, quince preserves, plum preserves, pear preserves, apple pie, pumpkin pie, peach cobbler, cream pudding, maple syrup, honey, peaches, sweet cream, doughnuts, pound-cake, sweet milk, butter milk, clabber, sweet cider, hot coffee. . . .

discussing cases and swapping stories that when they separated next morning, each resolved in his own mind that this meeting should not be the last."

Idea for Medical Society Born

"As our Wabash Valley doctor rode homeward, . . . he found himself mentally asking the question, 'If so much satisfaction and helpfulness can come from the meeting of two physicians why can not a corresponding degree of profit and pleasure be derived from the coming together of six and maybe a dozen?' Then came the Idea. The Idea—forceful, dominant and that like Banquo's ghost would not down. The Idea—that imprinted itself so indelibly on the brain of our Wabash Valley doctor that it gave him no peace of mind 'till he had mentally planned the coming together of the physicians in his locality and joining hands with them in the organization of a medical society."

"For a time unexpected obstacles were encountered and the contemplated enterprise was not consummated as soon as desired. But if with proverbial deliberation the Gods ground slow, they also with traditional thoroughness ground so fine that eventually a meeting held at Lawrenceville, in 1846, resulted in the organization of the Aesculapian Society. . . . "

Earliest Members

"Prominent among those who attended this meeting are the names of Drs. David Adams, Elisha C. Banks, J. M. Doyle and Charles M. Hamilton."

"Save Dr. Hamilton I knew none of these earlier men personally. Indeed, for the most part they had done their work and passed off the stage before I entered the profession. . . . "

"With the immediate successors of this first generation of Aesculapians it was my fortunate privilege to become acquainted some thirty-odd years ago. And in the forefront of this second generation are the names of Drs. A. J. Miller, John TenBroeck, William Massie, James M. Steele and William M. Chambers, each of whom had an individuality and general make-up all his own. . . . "

"Thus we see: The first generation gone into history: The second generation gone into history: The third generation fast passing into history: But happily the fourth generation, in the prime and flower of manhood, has in its safe keeping our beloved Society, stronger, more aggressive, more useful and in every way better than ever before! Verily, 'One generation passeth away and another generation cometh, but the 'Aesculapian' abideth forever.' "

We may add in 1968, that the fifth and sixth generations are now in charge.

Early growth of the group was phenomenal. The meetings always lasted two days, and many in attendance used a day in coming and another in returning. Population in the area was increasing; the Alton and Terre Haute, the Ohio and Mississippi, and Illinois Central Railroads were built; roads were improved and buggies and carts were plentiful; and the Aesculapian Society flourished.

Because travel was difficult these doctors of the past had to exert a great effort to attend the meetings of the Society. Their meeting must have been the highlight of the year. At first they travelled by horseback, perhaps taking several days to make the trip, later by horse and buggy or maybe stage coach, later by train and today by automobile. In those early days there were no journals, no closed circuit television, (yes, and no detail men); so to satisfy their thirst for the latest in medicine they put forth the greatest effort to attend the annual meeting of the Society. It is our hope that this great old medical society will never die but will continue as a living memorial to those hardy pioneer doctors who first ministered to needs of the people of the Wabash Valley.

References

1. Eckert, Allan W. *The Frontiersmen.* Boston, 1967. pp. 57-61.
2. Ibid. p. 78.
3. Allen, John W. *Legends and Lore of Southern Illinois.* Carbondale, 1963. p. 13.
4. "Proceedings and Presidential Addresses of the Aesculapian Society of the Wabash Valley," Volume III; Paris, Ill., 1912.
5. Hunt, George W., M.D., "Historical Sketch of the Aesculapian," read at Lawrenceville, Ill., May 28, 1931.
6. Proceedings and Presidential Addresses of the Aesculapian Society of the Wabash Valley," Volume V; Paris, Ill., 1916.

Surgery In Infertility

By A. F. Lash, M.D., Ph.D./Chicago

Surgery in infertility is considered when all other therapeutic measures have failed or there is an obvious causative factor present which can only be corrected by an operative procedure. Surveys of fertility studies have indicated that the lack of therapeutic success results from inadequate studies of the couple. It is most important to thoroughly investigate a couple to determine the presence of one or multiple factors contributing to the sterility. The obvious cause may be only one of several contributing factors. It is well to apprise the couple of the prognosis of the procedure contemplated, so that there may not be too great an expectation, followed by disappointment. Surgery may establish the incurability of the sterility so that they may start adopting their children without further delay.

Considering the lower genital tract, the obstructive anomalies encountered are: fibrotic hymen preventing penile introition, transverse vaginal septa, and partial or complete absence of the vagina. These conditions may be corrected by surgery and conception will follow if the upper genital tract is normal.

Dilation with Stem Pessary

The cervical obstructive lesions may be strictures or synechiae due to chemical, cautery, infection or poor healing after surgery. In order to render it normal, dilatation with stem pessary may be necessary. Therefore dilatation and curettage is part of the surgical study of all sterility problems and usually combined with culdoscopy. Its relation to synechiae will be considered under uterine factors. Also cervical polyps, erosion or eversion, cervical fibroids or prolapsed submucous fibromyomata must be dealt with surgically. Contrawise, lacerations through the whole length of the cervical wall or only at the isthmus produces incompetency of the internal os with resulting repeated abortions. These individuals are just as infertile as those who are unable to conceive because they are unable to carry a pregnancy to maturity. Repair of these traumatized cervices allows for normal pregnancies to go to term. The visible lacerations are obviously recognized and trachelorrhaphy restores them to normal functions. The less commonly injured isthmial area is not readily diagnosed without exploration of the cervicouterine canal and determining the abnormally enlarged internal os with a defect (scar) in its circumference. Its presence is confirmed by the cervicohysterogram which not only establishes the abnormal orifice but on transverse or oblique views may disclose the defect. The wedge shaped excision of the defect or scarred tissue and closure of the resulting wound, restores the normal competency of the isthmus. When this condition becomes manifest during the second trimester of a pregnancy by beginning effacement and dilatation plus herniating B.O.W., the canal may be closed by circlage procedures which may allow the pregnancy to progress normally.



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Uterine Factors Concerned

The uterine factors playing an important role in infertility are readily recognized in the course of an adequate diagnostic investigation. These uterine factors which concern us in a therapeutic surgical approach are anomalies, endometrial synechiae, polypi, fibromyomata and fixed retrodisplacement due to adhesions (endometriosis or P.I.D.). Among the anomalies, the subseptus and the bicornuate uni-

collis variety usually require operative correction after repeated[4] abortions. The Strassmann[23] technique has been utilized with the definite effort being made to prevent adhesions between the wound and loops of intestines. The vesicouterine peritoneum, the round ligaments or free transplants of the omentum are used to leave a smooth surface toward the peritoneal cavity. In 1954 Steinberg[21] reported a collection of 107 cases operated on by Strassmann method. Of these, 61 had become pregnant and 51 of these pregnancies had resulted in the birth of living children.

Adhesions Loosened

Atresia of the endometrial cavity, partial or complete, resulting in amenorrhea and sterility is rare. The partial type may be helped by probing and gradual dilatation. These atretic conditions result from overzealous curettage, manual removal of the placenta or intrauterine packing. Ascherman suggested manual loosening of these adhesions in association with abortion or delivery. He reported of 158 such patients, only 33 became pregnant. In 20, pregnancy went on to term, six aborted and four terminated in premature delivery while two of his patients were pregnant at the time of his publication. Of Bergman's 30 patients 16 were involuntarily sterile. There is no generally recognized form of treatment for these traumatic lesions. If recognized during an abortion or delivery the adhesions may be manually loosened. Brett and Legros have suggested hysterotomy as a means of liberating intrauterine adhesions.

Although the prognosis is poor in the presence of marked adhesions, additional indications such as incapacitating dysmenorrhea may make surgery necessary. Transplantation of endometrial tissue in the treatment of these traumatic conditions have been described by several investigators. (Gruenberger, Serdjukoff, Siebke and Westman.) Westman reported instances of recovery of menstruation followed by conception. However, spontaneous regeneration of the mucosa may also occur. In Bergman's series of seven women, in four of them menstruation returned spontaneously without therapy, after one, two, three and six years respectively. Paul Strassmann in 1929 successfully transplanted a fallopian tube into an artificially created uterine cavity. Erwin O. Strassmaun reported on the surgical reconstruction of a functional uterine cavity in six patients having complete atresia. In all six, menstruation was reestablished. One patient who became pregnant went to term. Fortunately this uterine factor does not occur too often to be a serious infertility factor. However in the last two years, a number of series have been reported by Musset, Netter and Solal, Onetto et al, Pinto and Sweeney.

Myomatous Uterus

Fibromyomata are not uncommon (Rubin) and the incidence varies with the race and age of the individual (Barter and Parks). About five percent of all patients complaining of infertility will possess a myomatous-uterus which may account for their infertility problem, either partially or completely. According to Rubin's statistics, 42 percent of his patients operated for myomas did not conceive while the incidence of sterility in the general population is about 15 percent. The mere presence of myomas in the uterus of an infertile woman does not imply a causative relation. Only when a thorough investigation has established the husband's fertility potential and ruled out any cervical or tubal factors, myomectomy may be indicated. Surgery is the only means by which fibromyomata associated with sterility can be eliminated. No hormone therapy has been found effective in inducing shrinkage or disappearance of these tumors. The sterility or infertility is caused by the obstructive nature of the tumor at the tubal or cervical orifices, distortion of the uterine cavity or by the endometrial changes, hyperplasia or atrophy induced by the location of the fibroid; also the disturbances of circulation in the tumor with their resulting degenerative changes and their irritative effects upon the uterine muscle during pregnancy resulting in abortion or premature labor. Tubal disease is not infrequently concomitantly present.

Myomectomy may be single or multiple and currently is a relatively safe procedure. Certain principles must still be followed to avoid complications. A routine Papanicolaou smear and diagnostic curettage must be performed on every patient regardless of age, particularly if there is menstrual disturbance. Personal experience with both cervical and endometrial car-

cinomas associated with fibroids in the second and third decade of life in patients coming for an infertility problem are the basis for the emphasis on these simple diagnostic measures. At the same time the presence of submucous fibroids, of hyperplasia and polypi or atretic areas may be determined. The guiding surgical principles are: complete hemostasis, removal of as many fibroids as possible through one uterine incision, even invading the uterine cavity for the submucous type, properly coapting of uterine wall edges as in a cesarean section, results in good wound healing; redundant uterine muscle should not be trimmed because it usually shrinks. Sutures should not be tight or too close together so necrosis will not occur. The serosal layer sutured with #00 chromic catgut should leave a smooth surface or a free omental transplant may be used to cover the wound with #0000 chromic catgut to tack down the edges of the transplant. The vesicouterine peritoneum or the round ligaments may be utilized for peritonealization purposes. Avoiding adhesion of the small bowel to the wound will prevent a possible future bowel obstruction. This complication becomes serious especially during pregnancy. The future course of pregnancy is usually good and the character of the delivery will depend on the cephalopelvic relationship, the position and variety of the presenting part as well as the character of the labor. It is obvious these women in labor are more closely watched and under proper indications abdominal delivery is anticipated sooner than in a normal uterus.

The fixed retrodisplacement of the uterus will be dealt with in dealing with the tubal factor.

Common Factors in Sterility

The most common factor in sterility in the female has been tubal obstruction due to infection. The diagnostic procedures of culdoscopy and pertinoscopy play an important part in revealing tubal obstruction in the absence of palpatory findings. Salpingograms are necessary obviously in determining the sites of obstruction. Hydrotubation may be utilized in conjunction with the above mentioned procedures before, during and after surgery. Colored liquids may be used to guide the observer to the point of obstruction. Therapeutic agents introduced via hydrotubation may be spasmolytic, mucolytic, antibiotics (large spectrum antituberculous), and cortisone. The aim of hydrotubation is to release tubal occlusion and promote favorable changes in the tubal mucosa. Since partially open tubes do not necessarily mean functional tubes, these various therapeutic agents help to restore normal physiology of the tubes.

When the medical measures fail and culdoscopy or peritoneoscopy reveal adhesions, constricted or adherent tubes to ovary or surrounding structures, then surgery is required.

Surgical Procedures

The surgical procedures to restore patent tubes are: 1. salpingolysis; 2. salpingostomy; 3. implantation of intact patent tubes into the cornua; 4. end to end anastomosis after removing the impassable obstruction or after a section of a tube has been removed with an intact tubal pregnancy. When there is no tubal conduit available, then the ovary may be transplanted into the cornuae of the corpus.

The fine fimbrae of the tubes when agglutinated require the gentlest manipulation with sharp dissection to achieve favorable results by salpingolysis, the minimal procedure in tubal operations. For salpingostomy either a cuff or linear technique as well as end to end anastomosis may be performed. Not only gentle handling of the tissues is necessary but also fine catgut or teflon suture (#0000 or #00000) is essential. Having achieved patency, retention is the ultimate aim of all these efforts. The postoperative care will be described later.

Ovarian Conditions

The ovarian conditions contributing to sterility and requiring surgery are, essentially, pelvic inflammatory disease, neoplasms, polycystic ovaries and endometriosis. Although being repetitive, it is important to emphasize sharp dissection, gentle manipulation, finest adequate suturing hemostasis and supportive procedures for the ovaries.

The ovaries are usually involved with the tubes in pelvic inflammatory disease. In post gonococcal infection, adhesions are readily separated and the ovarian envelop of adhesions may be readily removed. How-

ever, the postabortal or mixed streptococcal infection or post appendicial type are more difficult and give poor postoperative results. One must be alert for tuberculosus infection adhesions which grossly resemble the nonspecific type. It requires keen judgment to allow tuberculosus pelvic structures to remain and to depend on chemotherapy for cure. Burnt out ovarian abscesses and cysts may be resected.

Bilateral dermoid and other benign neoplasms are occasionally encountered and may be removed by resection, retaining functioning ovaries. It is surprising at times what small portions of ovarian tissue may be functional. Therefore all efforts must be made to retain ovarian tissue. Only in the presence of bilateral malignant neoplasm is one justified in sacrificing all ovarian tissue.

It is common knowledge at present that the polycystic ovaries (Stein-Leventhal) will respond to careful ovarian wedge resection. Normal menstruation follows in 90 percent of instances and gives about 60 percent good outlook for pregnancy to follow.

Progestin Therapy=Surgery

Currently endometriosis of the ovaries and pelvis are subjected to progestin therapy with the hope of resolution of the lesions and the likihood of pregnancy following. When this expected result does not occur and symptoms or infertility persists after an adequate time interval then surgery is indicated. In a recent report of a large series of infertile patients (283) with endometriosis, Alan Grant found that these patients are subject to a wide range of associated pelvic disorders. The first physiologic mechanism to deteriorate is that of the corpus luteum. Therefore conservative surgery should be the primary treatment, with progestrogens a secondary therapeutic measure. Of 246 patients, 94 or 38 percent became pregnant (including nine miscarriages and three tubal pregnancies). The operative procedures performed are: (1) resection of ovaries, (2) destruction or removal of implants on the pelvic peritoneum, (3) usually uterosacral ligament reefing to give better support to the ovaries by creating better fossae for the ovaries to rest in and incidentally decrease the dilatation of the pampiniform venous plexus. Presacral nerve resection may also be considered. The shortening of the uterosacral ligaments may also help the position of the retroverted or retrocessed corpus uteri. Less commonly the Barrett round ligament shortening operation is also used.

Although the anatomical sites of the generative tract were considered separately, not infrequently multiple sites may be the seat of pathology requiring surgical attention. Therefore it is important to include all sites in the surgery. Further postoperative care is important in the form of hydrotubation. Currently, much emphasis has been put on hydrotubation postoperatively as well as preoperatively. Colored (indigo carmine) fluid in hydrotubation helps indentify points of stricture and obstruction in tubes. The distal obstruction is found five times more frequently than the proximal. The cornual obstructions accounts for ⅔ of the failures. Hydrocortisone hydrotubation (10 mgms in 50 ml. of normal saline) is suggested by several investigators, about three times in ten days in the hospital. A Rubin test may be done immediately after the first period following the operation. During this hospital stay the patient is covered with antibiotics and antibacterial agents. To reduce painful reactions, phenergran and antispasmodics are utilized. Some suggest a hydrotubation (about 10 ml.) mixture of penicillin, streptomycin, soludecadron, hyaluronidose and alpha-chymotrypin. This mixture is slowly injected in the first half of each cycle following the plastic surgery two or three times. The aim of the hydrotubation is to release tubal occlusion by adhesions following surgery and to promote favorable changes in the tubal mucosa.

The Rock-Mulligan hoods are most effective in keeping the fimbriated ends open. A secondary operation is necessary in two or three months to remove them.

Recently Hurteau and Bradley have reported experimental studies in animals on the use of a mechanical stapler, comparable to that used for anastomosis of blood vessels and ureters. Although there has been some increase in success in the salpingolysis procedures; the salpingostomy and the cornual implants still give a low percent of good results. An open

tube does not necessarily mean a functioning tube.

Summary

In summarizing, the results of surgical effort to restore fertility are least rewarding in the site of greatest incidence of etiologic factors, the fallopion tubes. The prospects for organ transplant may not be too far in the future. Dog experimentation suggests that clinical uterine ovarian homotransplantation would probably be feasible should the immunologic rejection problems be solved.

References

1. Ascherman, J. G.: Amenorrhea Traumatic (Atretica): J. Obst. & Gynec. Brit. Emp. 5:23, 1948.
2. Ibid: Internat. J. Fertil. 2:49 1957.
3. Barter, R.H. and Parks, J.: Myoma Uteri Associated with Pregnancy, Clin. Obst. & Gynec. 1:519-533, 1958.
4. Bergman, P.: Treatment of Sterility of Intrauterine Origin, Clin. Obst. & Gynec. 3:852-861, 1959.
5. Brett, A. J. and Legros, R.: Evolution of Treatment of Uterine Corpus Synechiae of Traumatic Origin, Rev. Fronc. Gynec. et Obst. 61:107-122 (March) 1966.
6. Eraslan, S. et. al: Successful Pregnancy After Experimental Uterine-Ovarian Replantation Arch. Surg. 92:9-12, 1966.
7. Grant, A.: Additional Sterility Factors in Endometriosis Fertil. and Sterility, 17:514, 1966.
8. Gruenberger, V.: Proc. Second World Congress Fertil. & Steril. 2:248, 1956.
9. Hayashi, M.: 5th World Congress of Internat. Fertil. Assoc. Stockholm, Sweden, June 16-22, 1966.
10. Hurteau, G. D. and Bradley, G.: Evaluation of the Stapled Anastomosis in Experimental Salpingoplasty. Fertil. and Sterility, 17:323, 1966.
11. Mackey, R.: 5th World Congress of Internat. Fertil. Assoc. Stockholm, Sweden, June 16-22, 1966.
12. Mulligan, W. J., Rock, J. and Easterday, C. L.: Use of Polyethylene in Tuboplasty, Fertil. and Steril. 4:428-435, 1953.
13. Musset, R., Netter, A. Solol, R.: Repercussion of Traumatic Uterine Synechiae on Reproductive Function, Presse Med. 73:2137, 1965.
14. Onetta, E., Saavedra, R., Crisosto, C. and Hamblen, E. C.: Treatment of Uterine Synechiae with Help of Iatrogenic Pseudopregnancy: Anatomic and Functional Results Internat. J. Fertil. 10:217, 1965.
15. Palmer, R.: 5th World Congress of Internat. Fertil. Assoc. Stockholm, Sweden, June 16-22, 1966.
16. Pinto, V. B.: Uterine Synechiae Rev. Obst. y Gynec. Venezuela 25:272, 1965.
17. Roch, J.: Investigation and Treatment of Infertility M. Clin. North America 91:1171, 1948.
18. Rubin, I. C.: Uterine Fibromyomas and Sterility Clin. Obstet. & Gynec. 1:501-518, 1958.
19. Serdjukoff, M. G.: Ber Gynak. 28:551, 1935.
20. Siebke, H.: Zentralbl. Gynak. 22:1034, 1941.
21. Steinberg, W.: Obst. & Gynec. Surv. 10:400, 1954.
22. Strassman, P.: Zentrabl. Gynak. 31:1322, 1907.
23. Strassman, P.: Zentrabl. Gynak. 52:2626, 1930.
24. Strassman, E. O.: Surgical Reconstruction of a Functioning Uterine Cavity in Six Patients Having Complete Atresia South. Med. Jour. 49: 458-563, 1956.
25. Sweeney, Wm. J.: Intrauterine Synechiae Obst. and Gynec. 27:284, 1966.
26. Westman, A.: Am. J. Obst. & Gynec, 61:15, 1951.

Utilization Review Guidelines Suggested

Utilization review is the sole prerogative of physicians and it has been held in this context in the implementation of Medicare programs. The Department of Public Health has formulated basic guidelines upon which it will base its investigations of utilization review committees. These recommendations should be followed by all physicians engaged in utilization review to obviate difficulties which may arise.

Listed below are the recommendations. If questions regarding phrasing or interpretation arise, it is suggested inquiry be made of the Department of Public Health.

1. That the committee meet regularly and that minutes be kept of the decisions.

2. That the committee make the required review of the long-stay cases within 7 days of the date they become "long-stay" cases, as defined in the review plan.

3. That the committee conduct the required review on a sample, or other basis, of admissions, durations of stay, and professional services rendered, as described in the written utilization review plan.

4. That physician members of the committee consult with the attending physician prior to deciding that further in-patient stay is not medically necessary.

5. That the committee provide timely written notice to the appropriate parties when it determines that further in-patient stay in a particular case is not medically necessary.

6. That the committee be composed of at least two or more physicians with or without the participation of other professional personnel.

7. That the committee have at least one member who has no financial interest in the institution.

These guidelines will be the basis upon which the Department of Public Health will base its investigations of utilization review committees.

Comprehensive Health Planning in Illinois

By Francis J. Weber, M.D., M.P.H., Dr. P.H./Springfield

I. Beginnings of Health Colloboration Efforts

The attempt to plan comprehensively for health activities, which means any and all such efforts for which the state is officially charged, is so new that definable results are yet to appear. Therefore, the quickest way to the heart of the matter rests in examination of what governing legislation provides as the *raison d'etre* for passage of such legislation.

Comprehensive Health Planning is now provided for in what is popularly called the "Partnership for Health" program, a new undertaking with a legal base in the 1966 amendments of Public Law 410 (79th Congress, July 1, 1944) under which the U. S. Public Health Service operates. The new amendments are contained in Public Law 89-749 (89th Congress, November 1, 1966).

Many will recall that the Public Law 410 mentioned, after its July 1, 1944 enactment, came to be regarded as a milestone in health legislation. It successfully brought together in one place many earlier and separate pieces of Federal legislation that authorized various public health and medical programs, the first one of which enabled establishment of the U. S. Marine Hospital Service in 1798.

Therefore, we can say a form of health partnership emerged early, one strengthened in succeeding years, beginning with various campaigns to eliminate epidemic spread of communicable diseases. If the 19th century can be regarded as an era of basic medical discovery, in building upon that our 20th century has been forced into an ever widening circle of medical and public health collaboration. A Public Health Service Reorganization Act, even as early as 1902, recognized a need for a formal partnership when Congress established the Conference of State and Territorial Health Officers with the Surgeon General.

Besides a growing sense of partnership, in which organized medicine plays a significant role, one can read into accounts of the period, deliberate efforts to develop some systematic approach to health problems where the general community was the focus of concern. Soon the expanding content of medicine and public health began to be reflected in many interesting ways. One revealed itself in our increased knowledge of prevention, a fruit of medical research and empirical observations. Its steady growth gave sufficient content to render feasible organization of full-time state and local health departments. Deliberate planning was provided for in such connections and we were not long in discovering that good results in this type of effort depend in large measure on wide community involvement. It is this type of involvement we hope to formalize in the activity of the so-called regional (as contrasted with state) comprehensive health planning agencies to be described later.

In any case, the July 1, 1944 birth-date of Public Law 410, (the 1966 amendments of which we are considering here) found those of us who were members of medical and public health professions at that time, in possession of certain basic elements necessary to sound health organization and well conceived program content, ones upon which we still depend to provide essential ingredients for comprehensive health planning. These include: a body of medical, plus other forms of knowledge relevant to health, that lends itself to disease prevention via health protective and health promotion measures; an awareness of environmental and human ecological problems along with some well founded notions governing employment of needed corrective measures in solving problems resident within that realm; the beginnings of a

flourishing research effort that has since proved its worth in dealing with an altered disease picture while mounting research has provided multiple options for therapy; and finally, a good understanding of what an organization requires in various special areas when it arrives at the actual "doing" stage.

A point is made of such developments because the planning activities we are to consider, authorized under Public Law 89-749, represent another necessary stage in organized health work as an outcome of the abundant health programs Public Law 410 encouraged.

II. *General Provisions for Planning as Contained in the Form of Amendments to Section 314, Public Law 410, 78th Congress (1944)*

The changes in Section 314 come under the title of "Comprehensive Health Planning and Public Health Service Amendments of 1966" and have been designated collectively as Public Law 89-749, 89th Congress (1966). Many will recall that Section 314 of Public Health Law had enabled cooperative work, including grants-in-aid to public and other non-profit health agencies, e.g., 314 (a) provided support for the highly successful Venereal Disease Control effort of the 30's and 40's, 314 (b) authorized comparable activities for Tuberculosis Control starting in 1944, and so on. Fortunately, experience with such activities has disclosed certain factors that need be taken into account once communities become concerned in particular aspects of health status. In leaping over the intervening period to nearly a quarter century later, we are free to consider what the 1966 legislation on health planning enables us to do.

Provisions for the "Conduct" of Comprehensive Health Planning

This is considered under three subsections of 89-749: 314 (a) concerns *state level* planning, including financing the same; 314 (b) authorizes "Project Grants for Areawide Health Planning," enabling development of Comprehensive Health Plans at a *regional, metropolitan,* or other *local area* level, and 314 (c) authorizes "Project Grants for *Training, Studies* and *Demonstrations*" to, so to speak, "improve the state of the art" in health planning fields.

Formation of a Division (the State Comprehensive Health Planning Agency) and a State Advisory Council

Since an important requirement, Amendment (a) to 314, provides for *a single state comprehensive health planning agency* be designated by the Governor, the State Department of Public Health has been named Illinois' official health planning agency. Along with this action a Division of Health Planning and Resource Development was established for the purpose of forming an organization capable of discharging responsibilities assigned through this legislation. An important one of these consists in preparation of an Annual State Plan, which will take into consideration all aspects of health in the State, one which is also expected to indicate how progress toward health goals and objectives will be measured and evaluated. Therefore, compared to past Federal requirements for planning document submittal, as a condition for receipt of Federal Grants-in-Aid allotted the Department, the present requirement for a planning document calls for a much broader scope (as befits the term, "comprehensive") as well as one with more detail. Another provision (314 (a) (2) (B)) gives the Governor responsibility to form *a state health planning council,* one which:

a. Is so organized that a majority of its members represent "consumers of health services," and

b. Renders advice to the state health planning agency on matters coming within its purview, including review of the agency's annual statewide comprehensive state plan.

Gov. Shapiro brought the Illinois Health Planning Advisory Council into being May 28, 1968, and named Dr. Clifton L. Reeder, Chicago, as Chairman. The Council numbers 67 members.



Dr. Weber is Chief, Division of Health Planning and Resource Development, Department of Public Health, State of Illinois.

Comprehensive Health Planning on a Local or Regional Basis.

An important new feature in health planning is provided for under another amendment (of Section 314) enabling regional, metropolitan or other local areas that qualify to form Comprehensive Health Planning Bodies via Project Grant assistance. These entail:

a. Federal financing up to 75% of cost;

b. Grants that may be made to either governmental or voluntary non-profit agencies undertaking plan development, except that only one such group can be accorded official state recognition for any one area. Many Illinois communities have already expressed great interest in forming regional planning groups and two metropolitan areas have progressed to the point of grant application submittal.

Studies, Demonstrations and Training Activities in Support of Comprehensive Health Planning

A third amendment (c) to Section 314 enables financing of activities *designed to effect improvements* "in the state of the art" apropos comprehensive health planning: studies; demonstrations; training activities. Qualified public or private nonprofit organizations, with interest in improving health planning performance, are eligible for sponsorship. Thus far the principal interest has been in applications for educational and training efforts. While this is encouraging, we would like to see certain difficult problem areas made subjects for study, utilizing this type of project support. There is an opportunity, especially for county medical societies, to work in regional comprehensive health planning, and to conduct project studies as a form of necessary applied research. Insights gained from such studies can be of great help to making planning more realistic as well as more helpful to the public.

Early Indications for Organizational Emphasis

Up to this point, we have considered in just the briefest fashion the principal legal authorizations for health planning, plus a few early steps taken under them toward organizing Illinois planning functions. With just a few months in which to carry out such things, we needed to assign some order of priority, in terms of actions demanding first attention. Now that such are well started, increased emphasis becomes possible for work in what may eventually prove to be the most significant part of the statewide program, the local areas.

These are now evincing strong interest in organizing for comprehensive health planning. When incorporated, such groups, sometimes called the 314 (b) agencies, (let us say "B") must evolve as well functioning regional units, if all statewide objectives are to be adequately met. Because of the multitude of health programs now impinging on the local scene it is felt that intimate, day-to-day local involvement is a necessity for long term, sound health planning and management. Physicians, through their official organization (or individually at times), must be at the center of planning organizations. At the same time, health concerns are so wide-spread a confinement of planning to physicians alone when we concern ourselves in regional or community-wide planning would not prove adequate. On the contrary, other professional bodies with direct concern (e.g., hospital administrators and their advisors), official health agencies, welfare associations, especially those with public responsibility for medical relief of low income families, need also be associated professionally.

The Matter of Legislative "Intent"

Because of the effort's newness, special attention has been given interpretation of legislative intent underlying various provisions of 89-749, especially the extent to which the latter might modify earlier ones. Congressional attitudes in these respects are probably best expressed by Section 2 (a) and (b) of the Act under "Findings and Declaration of Purpose:"

"Section 2 (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be di-

(Continued on page 299)

Tour of President of ISMS Presents Varied Program

Plans for the new enhanced President's Tour '68 programs, starting in September, are well along.

Blending insights into vital issues with sociability, programs already have been set for Rockford Sept. 10 and Nov. 6; Carbondale Sept. 24 and 25; Alton Oct. 2; Joliet Oct 9; Peoria Oct. 10 and 11, and Moline Oct. 23.

Highlights at each place will be:

*A Workshop on Government Health Programs, to show physicians and medical assistants how to file claims accurately and get prompter, fuller payments. Representatives of state agencies and insurance carriers will outline procedures—and answer questions—on Medicare, Medicaid, (public aid) and combinations of the two . . . general assistance, vocational rehabilitation, children and family services, and military dependents care (CHAMPUS).

*A President's Dinner for physicians and their wives. Dr. Philip G. Thomsen, ISMS president, or Dr. Edward W. Cannady, president-elect, will talk on issues covered in the questionnaire mailed to all members in July, and tell how members voted. A prominent public official also will speak.

Dr. Thomsen or Dr. Cannady also will hold press conferences, appear on radio or television, and address civic clubs.

At most places, the programs will be on a district-wide basis.

As this issue of the IMJ went to press, the schedule included the following arrangements:

Rockford—Tuesday, September 10: Talk by Dr. Thomsen to Rockford Kiwanis Club, which meets at 12:10 p.m. in Faust Hotel. President's Dinner, Henrici's Restaurant, at 7 p.m., preceded by cocktail hour and concluding with addresses by Dr. Thomsen and a political figure; ISMS and Winnebago County Medical Society will cosponsor the dinner. Wednesday, Nov. 6: Workshop on Government Health Programs at 1 p.m. in Faust Hotel.

Carbondale—Tuesday, Sept. 24: President's Dinner at 7 p.m. (with a 6 p.m. reception) at Holiday Inn, in cosponsorship with Jackson County Medical Society; address by Dr. Thomsen. Wednesday, Sept. 25: Workshop on Government Health Programs at 1 p.m. in Holiday Inn. Noon talk by Dr. Thomsen to Carbondale Rotary Club.

Alton—Wednesday, Oct. 2: Workshop at 1 p.m. in Stratford Hotel. President's Dinner in co-sponsorship with Madison County Medical Society; address by Dr. Cannady.

Joliet—Wednesday, Oct. 9: Workshop at 1 p.m. in Howard Johnson's Motor Lodge. President's Dinner there at 7 p.m. (with 6 p.m. reception); address by Dr. Thomsen.

Peoria—Thursday, Oct. 10: Workshop at 1:15 p.m. Friday, Oct. 11: Speech by Dr. Thomsen at noon luncheon of Peoria Rotary Club. President's Dinner arrangements are awaiting completion.

Moline—Wednesday, Oct. 23: Workshop at 1:15 p.m. in Holiday Inn. President's Dinner at same motel, with address by Dr. Thomsen.

Further stops—to be announced later—will take the President's Tour '68-'69 through the rest of the state.

Blue Shield Plan of Illinois Medical Service is sponsor of the manual to be used by registrants at the workshops.

New Film Catalog Available

International Film Bureau Inc., 332 S. Michigan Ave., Chicago, Ill. 60604, announced the publication of a new Health, Education and Welfare catalog containing descriptions of 127 16mm films and 42 filmstrips. The list of films includes such categories as Adolescence, Aging, Audio-visual Training, Child Care, Community Health Services, First Aid, Health—Cigarette smoking, Mental Health, and Mentally Handicapped Children. The filmstrips include series in Character Development, Child Training, and Municipal Government. For copies of this catalog or for additional information, write to:

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SOCIO ECONOMIC news

A service of the Public Relations and Economics Division

Payments to M. D.'s Upped by Fee Formula, IDPA Says

Payments to Illinois physicians for treating Medicaid (public aid) recipients are more than double the total that preceded adoption of usual, customary and reasonable fees, said Dr. Henry A. Holle. He is medical director of the Illinois Department of Public Aid. In the first five months of each year, the amount was $2,892,023 in 1966; $3,794,585 in 1967, and $7,349,134 in 1968. The u-c-and-r fee pattern became effective January 1, 1967, after agreement was reached between IDPA and ISMS. While the case load went up from 346,743 in April, 1966, to 425,508 last April, the higher payments result largely from the fee formula—and the fact that this formula has encouraged more physicians to take part in the program, Dr. Holle said. He announced the payment figures at the July meeting of the ISMS Board of Trustees. They were in line with predictions made by Harold O. Swank, IDPA director, and Dr. Philip G. Thomsen, now ISMS president, at the time the fee pattern was adopted.

ISMS Disaster-Care Stand Affirmed in State Senate

The Illinois Senate this summer adopted a resolution calling for adequate protection of medical personnel, hospital equipment and patients during civil disorders. It is modeled on a resolution voted by the ISMS House of Delegates in May and later by the AMA annual convention. The proposal originated in the ISMS Committee on Disaster Medical Care, chaired by Dr. Max Klinghoffer.

More Counties Move Forward In Comprehensive Planning

Will-Grundy, Lake, McHenry, DuPage and Kankakee County Medical Societies have been working toward formation of an areawide council for comprehensive health planning. "In other areas informational meetings are being scheduled and local planning councils are being formed," Dr. V. P. Siegel, chairman of the ISMS task force on comprehensive health planning, told the society's Board of Trustees in July. Already well along, the councils in Cook County and Greater St. Louis (including St. Clair, Madison and Monroe Counties, Ill.) have applied for federal grants. Made up of consumers as well as providers of health services, planning councils are to consider the full spectrum of health needs and goals.

Clark County Doctors Get ISMS Nod on Fee Plan

The ISMS Board of Trustees in July gave its assent to a "test" plan proposed by Clark County physicians who object to "accepting assignment" in Medicare/Medicaid cases. The plan calls for a uniform arrangement whereby the Illinois Department of Public Aid would pay the first $50 of each patient's annual bill under Medicare standards . . . the carrier would pay 80 per cent of the remainder . . . the physician would absorb the final 20 per cent . . . and no "assignment" of unpaid bills would be necessary. All billings would be under usual, customary and reasonable fee formulas. "We're giving the service for nothing now," said Dr. Eugene P. Johnson, president of Clark County Medical Society. To put the plan into effect, the Clark group would need approval from IDPA and the Social Security Administration. "From our standpoint, some of the bugs on deductible amounts would have to be ironed out," said Dr. Henry A. Holle, IDPA medical director. If implemented, the plan might set a pattern for other counties, said Dr. Johnson. A comparable program exists in Indiana.

Shapiro Urges Local Role in Mental-Health Care

Gov. Samuel H. Shapiro predicted that local communities will assume a much more important role in the state's mental health program. Addressing the Kiwanis Club in Chicago, he commended recent votes in various localities to set up mental health services. The short-term expense of such services, he said, is more than offset by the patients' earlier return to a productive life "and the decreasing need of direct care and family assistance funding."

Cost of Minor Surgery Up 50% Over 1955

The cost of minor surgical procedures in the U. S. has risen more than 50 per cent since 1955, according to a study conducted by the Health Insurance Association of America. The study covered charges and benefit payments under group insurance plans. It found that some 77 per cent of covered surgery charges last year were paid under group insurance contracts.

ISMS Malpractice Program Stirs Nationwide Interest

Inquiries from many out-of-state physicians have greeted ISMS' inception of a malpractice-insurance program. Several of these were from medical-society officers, who said their groups might sponsor similar coverage. More than 30 physicians, from California to Virginia, expressed an eagerness to enroll in the ISMS program; they had to be told that only ISMS members practicing in Illinois could enroll—partly because any premium-rate adjustments must be based on malpractice experience in this state. One aim of the program—which took effect in June—is to stabilize rates by improving the Illinois legal climate and discouraging bogus claims.

—By DON B. FREEMAN

In the complex picture of moderate to severe anxiety...



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effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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for moderate to severe anxiety and mixed anxiety-depression

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Pre-Admission Testing–A Blue Cross Proposal

By John C. Troxel, M.D., Senior Vice-President, Medical Director,
Blue Cross/Blue Shield/Chicago

With the costs of hospital care rising and many facilities strained, Blue Cross and Blue Shield's staff, with members of the medical profession, are constantly examining ways to encourage more economic use of available facilities and resources while providing maximal benefits for its members—at minimal costs.

Many people talk about the costs of hospital care but do nothing about it. Blue Cross and Blue Shield, assisted by physicians and hospital administrators, are trying to do something about it.

Members of the medical profession, Utilization Review, and Admissions Committees have worked hard to eliminate unnecessary admissions and to reduce the length of stays in the hospital. Changing concepts and advanced techniques have also successfully reduced hospital stays in special instances. For example, early ambulation and intensive rehabilitative procedures for surgical cases has not only reduced hospital stays but also has shortened the length of disability and improved the quality of care.

Thoughtful individuals in health care financing have asked themselves "What further can we do or suggest which may shorten hospital stays without compromising the quality of patient care?" By combining our thinking with that of practicing physicians, pathologists, radiologists and hospital administrators we have developed a plan which has the potential of shortening the "front-end" of some hospital stays. The plan is called "Pre-Admission Testing for Surgical Patients" or PAT, for short. It has been in effect for some time at a score of Illinois hospitals who wished to join the pilot project—and it works!

The plan is based upon the customary practice of physicians to have certain tests and examinations made before they undertake surgical procedures—tests which are designed to reduce surgical risk and to provide the surgeon with information which will aid in accomplishing his surgical task. The cost of such tests has usually been met by Blue Cross after admission to the hospital as an in-hospital benefit. We now propose to make the same benefits available when the tests are performed as hospital out-patient services.

It is not unusual for pre-surgical testing to require one, two or even more days in some instances, and when performed after admission may account for some wasted bed-days if the testing program could have been accomplished just as well on an out-patient basis. These are the days we seek to save—if they can be saved without detriment or serious inconvenience to the patient.

PAT does not provide a new level of Blue Cross benefits. It is only intended to pay for tests on an out-patient basis, which we have been paying all along on an in-patient basis. It should be clearly understood that PAT is *not* an out-patient diagnostic benefit program. (Blue Cross has out-patient diagnostic "riders" to its basic certificates which eligible groups may purchase if they wish such coverage and are willing to pay the additional price.) PAT will, however, provide the physician and his hospital with a mechanism which can make more efficient use of hospital beds and services.

In order for any Blue Cross member hospitals to participate in PAT its medical staff first must approve the program. The hospital administration must then set up facilities and services to implement the program and notify Blue Cross of its arrangements and the date it is to become effective.

(Continued on page 304)

Do you have patients who try to hide anguish behind arrogance?

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and release the patient

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(See last page for prescribing information.)

(Continued from page 290)

rected to support the marshaling of all health resources—national, State, and local —to assure comprehensive health services of high quality for every person but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

(b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible."

Examination of this statement, especially the terminal phrases of 2 (a), should do much to relieve any fears regarding an adverse impact on private professional practice. Rather than discerning intentions to inhibit free exercise of medical practice, we are inclined to look in another direction for explanation of this legal emphasis on health planning. In so doing, we are struck by the many types and varieties of health programs initiated since 1944-45, a majority of these federally sponsored and still growing, that now converge locally. Studies seem to indicate that the sheer rise in number raises certain administrative and budgeting problems, of which duplication and ongoing services overlap are commonly cited.

Public Law 89-749 Provisions for "Services"

Next, two other amendments in Public Law 749 represent an effort to consolidate categorical programs, or at least certain aspects of them, beginning with attempts at administrative consolidation.

Historically, Federal grants allotted to States have been weighted by certain factors, as: population, financial need, and extent of the problem. In that way the relative amount each was to receive from a single categorical appropriation was calculated. Until 89-749 amended procedures for categorical grants via part (d) applied to Section 314, each such categorical authority operated, as a general rule, its own fairly distinct administrative unit under a separate authorization. Currently, nine separate authorizations are now affected: General Public Health Services (its base in the original Title VI), Tuberculosis Control, Chronic Disease Services, Heart Disease Control, Cancer Control, Mental Health Services, Dental Health Services, Radiological Health Services, and Home Health Services. Under the Amendment (d) each has now been combined into one "block" grant, for administrative purposes. The law directs that at least 15% of any state's allotment must be remitted to the state mental health authority for its mental health services.

Health Services Development Project Grants

Subsection (e) amends Section 314 to provide these project grants for Health Services Development. These are available to cover part of the cost of: services that meet health needs of limited geographic scope or of specialized regional or national significance; and, new programs of health services with financial support confined to an initial period. These are the so-called "stimulatory" grants.

To qualify as a "new program" of health services one or more of the following conditions must be met:

a. The measures to be employed have not been applied beyond a successful developmental stage and demonstration;

b. The measures have not been applied in the location identified by the application; or

c. The measures will be extended to serve a population not now being served.

Program "fragmentation" at executive levels

In providing for Comprehensive Health Planning at the State (commonly called the "A" agency) or at a local, regional ("B" agency) level, we must be concerned with health matters generally within the jurisdiction covered. Therefore, health missions, goals, objectives and the general methods by which such are to be advanced are prominent features in plan preparation.

Federal requirements call for submission of such a Plan annually. This has been done for the first year of operation in Illinois (F. Y. 1968) as well as the present fiscal year, ending June 30, 1969. As regional or areawide ("B" type agencies) come into being, it is expected that these, too, will prepare such plans.

At the same time, it must be pointed out that, as matters now stand, guidelines set forth in the State "A" Plan (and this may be found to affect "B" agencies as well) have only limited application over the full range of federally supported health programs conducted in several States. As a prominent Public Health official, Dr. R. L. Smith, states: "It is obvious that the health services money contained in Section 314 (d) and (e), which must be spent in accordance with plans made by the State Comprehensive Health Planning Agency, is only a fraction of the health services money coming from the Department of Health, Education, and Welfare to the State. Other funds from the Public Health Service, Children's Bureau, Bureau of Family Services, Vocational Rehabilitation Administration, and the Social Security Administration also support health services in the State. However, Public Law 89-749 does not require that these other HEW funds be spent in accordance with plans made by the State Comprehensive Health Planning Agency."

"This fragmentation of Federal health dollars extends beyond the Department of Health, Education and Welfare. Depending on how they are counted, there are 40 to 100 different Federal programs funneling dollars into States in the health area. Each of these funds are interrelated. They are also interwoven at the point of delivery with State and local funds, and—largest of all—with private dollars. There is also a great deal of separate planning being carried out for each of these programs."

Dr. Smith then proceeds to suggest: "The State Comprehensive Health Planning Agency is the mechanism through which total health planning for the State can be done, and it is the mechanism that can recommend to the executors of State health programs the optimum health services which should exist for the citizens of the State."

From a consideration of such material, one is apt to conclude that were we without a state health planning agency, one might still want to consider creation of some general coordinating mechanism like it to deal with the proliferation of health programs observed throughout present day governmental structure. As it is, one might say of the current effort to begin Illinois' State Comprehensive Health Planning, it has begun at the highest possible executive levels—gubernatorial appointment of an Advisory Council accompanied by creation of a Division to devise workable plans for State and regional levels of operation—and all of this in close working association with professional organizations, of which the Illinois State Medical Society is a leading one. The latter's very able Task Force on Health Planning under the chairmanship of Dr. V. P. Siegel is one evidence of the way other involved professional groups view the need for effective partnership between governmental and private interests in this increasingly complex field of health.

The Congress has sometimes been rather specific in conveying its attitudes towards certain earlier established programs, which have included specific planning functions as part of their operations; for example, in that part of its Report on the Bill covering the relationship of comprehensive health planning to other planning activities under Labor and Public Welfare (No. 1655, September 29, 1966 that accompanied S. 3008) we read:

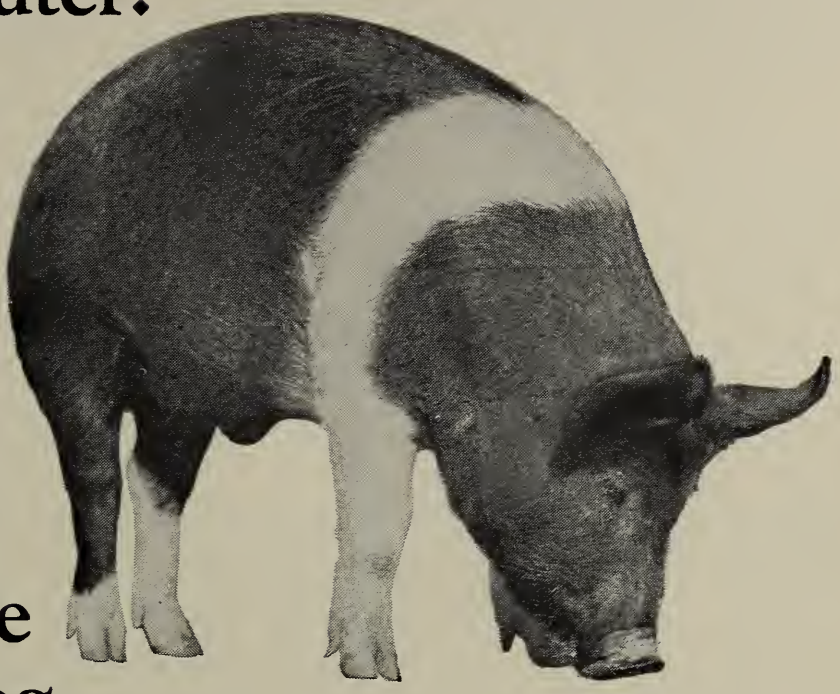
"The comprehensive planning of the State Health Planning Agency with the advice of the Council would complement and build on such specialized planning as that of the Regional Medical program and the Hill-Burton program, but would not replace them . . ."

"The State Health Planning Agency provides the mechanism through which individual specialized planning efforts can be coordinated and related to each other. The agency will also serve as the focal point within the State for relating comprehensive health plans to planning in areas outside the field of health, such as urban redevelopment, public housing, and so forth."

The relationship with Hill-Burton programs is quite close because of the activity of a Hospital Facilities Division responsible for continued prosecution of that program within the same Department as the Planning Agency. Even here, however, we note

(Continued on page 334)

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Pre-Admission Testing

(Continued from page 295)

PAT works this way: After the surgical diagnosis has been established, the surgical procedure scheduled and the patient's room reserved by the hospital, the physician orders those tests and examinations which he considers to be necessary before surgery is undertaken. The patient is instructed to report at a scheduled time and specific place in the hospital where the tests are to be completed. The results of the tests are reported to the physician and are made a part of the hospital chart at the time of admission. Charges for the tests are billed by the hospital to Blue Cross as a part of the bill for in-hospital care according to the benefit provisions of the patient's Blue Cross certificate.

The time period prior to admission during which the tests and examinations are to be made is determined by the medical judgment of the responsible physician. Obviously, most tests should be made as close to admission date as practicable in order that the test results may be completely dependable.

When the pre-admission tests are performed at the hospital where the patient is to be operated upon, the only circumstances under which Blue Cross will *not* make payments are for the establishment of the diagnosis, research, case finding, surveys or when the patient refuses the operation which his physician has advised and scheduled. Even when the operation must be cancelled or postponed for any reason outside the patient's control, Blue Cross will still make payment for the tests and when the operation is re-scheduled will make the same benefits available again.

It is hoped that all Illinois hospitals will adopt pre-admission testing for all elective surgical admissions, not for such Blue Cross admissions alone. We believe that significant savings in bed-days and alleviation of bed shortages can be achieved and if universally adopted would have the effect of creating hundreds of additional hospital beds and reducing the need for costly new construction.

PAT should help to relieve the peak loads on hospital clinical laboratory and X-ray departments by permitting the scheduling of tests during slack periods. Attending physicians would be assured of test results well in advance of the scheduled operation. The time patients would need to be away from their families and their gainful employment would be shortened.

We also view PAT as a way of stretching health care dollars by substituting less costly out-patient services for more costly in-patient services. We invite all Illinois physicians and their hospitals to consider this proposal seriously. Blue Cross representatives are available to meet with medical staffs so that we can combine our efforts in making PAT a successful and effective program throughout Illinois.

Enrollment in Blue Shield's Usual and Customary Program—which uses the ISMS definition of usual, customary and reasonable fees—has increased fivefold since its inception. Starting with employees of U. S. Steel in August, 1967, the program last July gained 200,000 members of Health Improvement Association, which consists of rural families. The health-insurance coverage is offered to groups of all ages.

Board of Trustees to Meet Downstate

The ISMS Board of Trustees will meet in Springfield October 5. The meeting will preceed the Annual ISMS Leadership Conference being held at the St. Nicholas Hotel, Springfield, on October 6.

The Board is meeting at this downstate location under the new proposal that it meet outside the Chicago area at least once a year to enable downstate physicians to attend.



"Will I ever catch up on my work?"

Mebaral® usually calms the anxious patient without the degree of languor, or decrease in alertness often caused by other barbiturates.[1] Mebaral is particularly valuable in treating anxiety-tension states *when minimal hypnotic action is desired.*[2] Its sedative action is prolonged[3] and predictable.

Contraindication: Large doses are contraindicated in patients with nephritis.

Warning: May be habit forming.

Precautions: As with other barbiturates, caution is advisable during use in debilitated and senile patients and in patients with pulmonary disease.

Adverse reactions: Although Mebaral is generally well tolerated over long periods, the possibility of idiosyncrasy to barbiturates (as manifested by drowsiness, vertigo, and cutaneous eruptions) should be considered.

Dosage: *Adults,* for daytime sedation—½ gr. (32 mg.), ¾ gr. (50 mg.) and, at times, 1½ gr. (100 mg.), three or four times daily.

References: 1. Musser, Ruth D., and Shubkagel, Betty L.: Pharmacology and Therapeutics, ed. 3, New York, Macmillan Company, 1965, p. 363. 2. Council on Drugs, American Medical Association: New Drugs 1965, Chicago, American Medical Association, 1965, p. 157. 3. Modell, Walter (Ed.): Drugs in Current Use 1966, New York, Springer Publishing Company, 1966, p. 77.

Winthrop Laboratories
New York, N.Y. 10016

Winthrop

Mebaral® tablets:
32 mg. .....(½ grain)
50 mg. .....(¾ grain)
100 mg. .....(1½ grains)

brand of
mephobarbital

DEPENDABLE DAYTIME SEDATION

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT



By Phyllis Bredthauer, CMA

The American Association of Medical Assistants is only 12 years old. It was formed in 1956 by a dynamic group of women who had the desire to continue their education and improve their knowledge and skills while working as medical assistants. Few girls had formal training, but learned to be medical assistants under the guidance of their physician employers. The organization is frequently abbreviated as AAMA. It has been closely associated with the American Medical Association. Members of the AMA helped to organize and continue to guide AAMA. Doctors serve as advisors not only to AAMA, but to the County and State organizations as well.

The duties of a medical assistant can be quite varied depending upon the type of office or hospital in which employed. As a good medical assistant, one should have a basic knowledge of medical terminology and an understanding of anatomy and physiology. One should be thoroughly acquainted with the spelling and meaning of commonly used prefixes, suffixes and root words as well as their combining forms. One should have some knowledge of the most common diseases which affect the different organs and be able to recognize which part of the body is involved in common surgical procedures.

The medical assistant should be aware of what constitutes acceptable professional and personal conduct and recognize individual responsibilities to the community. Personal qualifications should include physical fitness, appropriate appearance and grooming, and good personal hygiene. A mature and pleasant personality, emotional stability, and unquestionable integrity are requisite.

Medicine is an art as well as a science. Being an effective medical assistant is also an art. You must be able to put the patient at ease and gain his confidence. The medical assistant needs to know how to handle appointments of both a professional and non-professional nature and should understand basic telephone techniques regarding voice, tone, diction, and courtesy. You are expected to speak properly and grammatically, and to be able to exercise practical judgment, especially in an emergency.

An Assistant should have a broad working knowledge of the manner in which the law affects the practice of medicine, and also have a general knowledge of the economics of medicine. As a medical assistant, one should have a general knowledge of Medical Practice Acts, professional liability, and the legal relationship of physician and patient. One should know the different types of medical practice, the systems of medical care, and the basis for determining fees.

Sometimes the amount of knowledge and the amount of work seems overpowering to a prospective medical assistant. However, the AAMA offers education, counsel and guidance which allows one to increase one's efficiency and knowledge and surmount seemingly impossible work loads. There are many benefits from membership in the AAMA. These include: publications like the AAMA Bulletin—a professional journal which helps you to keep abreast of new aspects of medical assisting and up to date on AAMA activities throughout the nation; local chapter meetings at which you may listen to an expert on a particular subject of interest to medical assistants.

Physicians are encouraged to have their assistants become members of this important group.

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



ILLINOIS ASSOCIATION OF THE PROFESSIONS

Architecture
Medicine
Dentistry
Law
Engineering
Pharmacy
CPA
Veterinary Medicine

FIFTH ANNUAL MEETING
of the
ILLINOIS ASSOCIATION OF THE PROFESSIONS
October 11, 1968

Board of Directors Dinner Meeting
Thursday, October 10, 1968 - 6:00 p.m.

Annual Meeting
Friday, October 11, 1968 - 9:00 a.m. - 5:00 p.m.
Ambassador East Hotel, Chicago, Illinois
Program—Key Luncheon Speaker
Special Guests—Deans of Professional Schools in Illinois
Officers of Member Organizations
Ladies are most cordially invited to attend the meeting and functions.

Prepaid Prescriptions

Negotiations are continuing between Blue Cross of Illinois and the Illinois Pharmaceutical Association leading toward the implementation of a third-party payment program for prescription drugs, with administration provided by Blue Cross.

It is estimated that by 1970 over 70% of prescriptions dispensed will be paid for by a third party. With UAW employees scheduled to receive prescription drugs by October of 1969, it is expected that such benefits for other union members will quickly follow.

IAP Membership

Martin Sopocy, R.Ph., Chairman of the IAP Membership Committee, and his Committee are currently involved in a campaign to retain existing and obtain new members.

The theme of the drive states one of the major objectives of IAP, "To provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare."

A recent survey reveals that a relatively small percentage of professional association members in Ohio attend their annual conventions. The survey included Architects (9%), CPAs (7%), Engineers (10%), Attorneys (10%), Dentists (25-30%), M.D.'s (20%), Pharmacists (16%), Optometrists (33%), and Veterinariens (65%).

AAP Launched

Eighteen professional men, representative of eight professions and six major state associations of the professions, have met in Michigan to deliberate and subsequently recommend an organizational structure that will permit the American Association of the Professions to come to life as a representative of the professional segments of the nation.

Representing IAP was George B. Callahan, M.D. and C. Dale Greffe, P.E., both past presidents of the Illinois Association.

THE VIEW BOX

(Continued from page 264)

Diagnosis: Solitary bone cyst.

The age incidence of solitary bone cyst is anywhere between three and fourteen years of age. The usual site of localization is a long tubular bone with the strong predilection for the humerus. The patient is unaware of the lesion until a trivial trauma causes pain due to a fracture through the cyst itself. Radiographically the lesion is frequently found lying relatively near the epiphyseal plate. It does not involve the epiphyseal plate as a rule. The diameter of the bone may be expanded with considerable thinning of the regional cortex with possible fracture at one area of the cortex. As a result of the disappearance of the spongiosa markings, the affected area appears rarified to a greater or lesser degree. Occasionally the area may appear trabeculated which is due to the presence of ridges on the medullary surface of the modified cortex rather than bony partitions traversing and dividing the cyst. Multiple fractures may occur and the cyst will gradually work its way down the shaft of the involved bone. Pathologically the cyst contains fluid which may be clear and yellowish or else serosanguineous, particularly if there has been a recent fracture. As a rule, unless the cystic defect is obliterated by surgery it will persist indefinitely.

Reference:

Jaffe, H. *Tumors and Tumorous Conditions of the Bones and Joints,* pp. 63-75.

A color film designed as a basis for training courses in emergency cardiopulmonary resuscitation (CPR), and a manual which sets standards for instructors in the CPR technique, are available through the American Heart Association and its affiliates.

Entitled "Prescription for Life," the 48-minute film is intended for physicians, nurses and others qualified to perform CPR. It provides detailed anatomic and physiologic experimental and clinical information. Shorter versions of the film are also available. Both the film and the manual may be obtained through local Heart Associations.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Opinions and Reports on Ethical Relations

Propriety of Percentage Arrangement Between A Surgeon and A Clinic

The Council looks with disfavor on this type of arrangement as it tends to encourage fee splitting and rebates. The Council feels that the payment for expenses incurred by the clinic in behalf of the surgeon should be on a fixed rather than a percentage basis. The Council further believes that the surgeon should bill the patient directly. (Judicial Council, 1963)

Local Societies Must Combat Fee Splitting

As has been done in former reports, the Council wishes to record its condemnation of fee splitting wherever it may be found, and to urge component societies and constituent associations to purge their membership of any who willfully refuse to desist from such practice, the continuance of which can only bring dishonor and reproach on the medical profession. (House of Delegates, 1924)

Division of Fees and Acceptance of Commission

There have been widespread inquiries and complaints concerning the practice of medicine by hospitals, the division of fees between hospitals and doctors, the acceptance of commissions or rebates by ophthalmologists from opticians, the extensive unethical instances of contract practice particularly in the Pacific Coast states. Concerning all of these matters it is sufficient to say that wide extent of an unethical practice does not make it ethical. Ethics has to do with principles, not numbers or locality. A procedure unethical in one part of the country cannot be ethical under the same circumstances in another. Because the percentage of rebate is large in comparison, and in a year amounts to a considerable sum, and although many of the practitioners in a specialty may accept those rebates, the acceptance is no more ethical than for the general practitioner to accept a rebate on the occasional truss he may prescribe. The Judicial Council deplores such ignoring of ethical principles, not only because of the extent of the practice but because in many instances the plea of the financial necessity cannot be offered as an excuse. The Council can only publicize the abuses and express its severe condemnation of them. It has no power in itself of control or correction. (House of Delegates, 1934)

Division of Income by Members of A Group

The 1946 report of the Judicial Council states, in part, that "The division of income given to members of a group practicing jointly or in a partnership must be in proportion to the value of the services contributed by each individual participant." The 1947 report of the Council states, "Since the principles of ethics for private practice absolutely forbid the splitting of fees under any and all circumstances, the same rule applies to group practice; and the group formed must be a real partnership in which the total income is divided not equally but according to the individual income earned by the member."

In order to clarify its position with respect to the division of group or partnership income the Judicial Council approves and publishes the following rephrasing of its 1946 and 1947 reports on this subject:

The division of income among members of a group, practicing jointly or in partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group. (Judicial Council, 1959)

Profit-Sharing and Pension Plans

Profit-sharing plans which include lay employees are unethical.

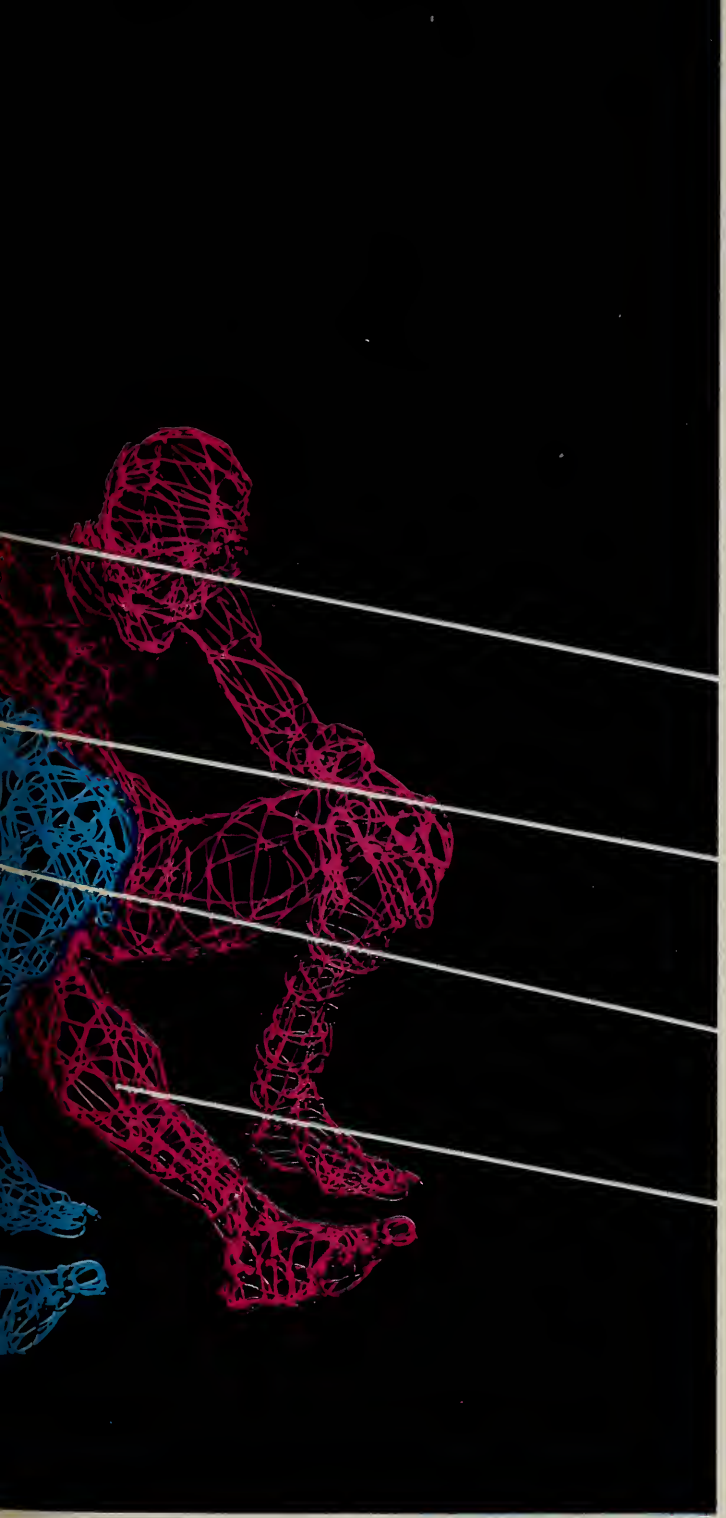
Retirement Plans

A retirement plan however classified under the Internal Revenue Code which also covers lay employees and which provides that the contribution made by a solo practitioner, a group of physicians, or a professional corporation will be based on a percentage of compensation of the participants, is ethically acceptable even though the contribution:

(1) is limited to a percentage of net income before taxes, or

(2) is payable only when net income exceeds a specified amount.

(Judicial Council, 1964)



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

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Lilly

Annual ISMS Leadership Conference

October 6

St. Nicholas Hotel - Springfield

Jacob E. Reisch, M.D., Secretary-Treasurer of the Illinois State Medical Society has announced the annual Leadership Conference date as October 6 in Springfield. The one-day meeting will provide State and county medical society officers, degelates and other key leaders an opportunity to hear experts speak on such medically important issues as the Partnership for Health Program, Health Manpower Problems, federal legislation, and the 1968 elections. A brief program listing follows.

MORNING

9:00 A.M. REGISTRATION

10:00 A.M. COMPREHENSIVE HEALTH PLANNING LEGISLATION—
National and State Background to Enable You to Judge Local Impact! Panel Presentation with Speakers from Washington, D.C. Office of Department of H.E.W. and FRANKLIN D. YODER, M.D., Director, Illinois Department of Public Health

NOON

12:15 P.M. LUNCHEON
HEALTH MANPOWER PROBLEMS—
Medicine's Response to a National Crisis
DWIGHT L. WILBUR, M.D., San Francisco, AMA President

AFTERNOON

2:00 P.M. ELECTIONS '68
PHILIP G. THOMSEN, M.D., ISMS President

2:30 P.M. LOWDOWN ON THE HIGHER-UPS AND PROJECTIONS OF THE 1968 PRESIDENTIAL CONVENTIONS & ELECTION
ROBERT D. NOVAK, Washington, D.C., Co-Editor of Syndicated Column **INSIDE REPORT** and Co-Author of **LBJ—The Exercise of Power**

3:30 P.M. FEDERAL FACT, FICTION AND FANTASY
Panel discussion by four prominent Illinois Congressmen and Legislators.

EVENING

5:30 P.M. FELLOWSHIP

6:30 P.M. DINNER
1968—YEAR OF DECISIONS
HON. EVERETT McKINLEY DIRKSEN, U.S. Senate Minority Leader

The 1968 Leadership Conference will be the best yet! Plan to attend this exciting and educational day. To register, clip the coupon below and mail to Jacob E. Reisch, M.D., 1129 South Second Street, Springfield, Illinois. Luncheon ticket is $3; Dinner ticket is $7.

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mail to: **Jacob E. Reisch, M.D., Secretary Treasurer**
Illinois State Medical Society
1129 South Second Street
Springfield, Illinois

Luncheon $3
Dinner $7

Enclosed is my check for $..... reserving ..... luncheon tickets and ..... dinner tickets. (Make check payable to Illinois State Medical Society.)

Name .....

Address ..... **City** ..... **Zip** .....

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

OBITUARIES

***Dr. Bart Cole,** Belleville, died July 14 at the age of 49. He was a past president of the St. Clair County Medical Society, director and board member of Our Lady of the Snows Foundation, past district governor of the International Serra Club and a past president of the East St. Louis Serra Club.

***Dr. Ewald Emil Hermann,** Highland, a former President of the Madison County Medical Society died May 24 at the age of 73.

***Dr. Martin G. Luken,** Chicago, died July 31 at the age of 85. He served on the medical staff of St. Elizabeth's Hospital and was Medical Director of Angel Guardian Orphange, a member of ISMS Fifty-Year Club.

***Dr. Mitchell J. Nechtow,** a Chicago physician for 31 years died July 17 at the age of 58. He was chief of Obstetrics and Gynecology at the Norwegian American Hospital, Professor of Obstetrics and Gynecology at Chicago Medical School.

***Dr. Grover Cleveland Otrich,** a Belleville ear, nose and throat specialist, died July 15 at the age of 83. He was an ISMS councilor for the Tenth District, Fifty-Year Club member, a former AMA delegate and a past president of the Central Illinois Society of Otolaryngology.

Dr. Samuel Perlow, Oak Park, 63, a practicing physician for more than 35 years, died July 5. He was a fellow of the American College of Surgeons, a member of the International College of Cardio-Vascular Surgery, and a diplomate of the American Board of Surgery.

Dr. Nathaniel Schaffner, Chicago, died July 18 at the age of 75. He was on the staff of American Hospital.

***Dr. Benjamin Franklin Shirer,** Batavia, 55, a practicing physician and surgeon for more than 30 years, died July 23. He was past president of the medical staff of Community Hospital and also of St. Joseph Mercy Hospital of Aurora.

***Dr. Samuel Stein,** a Chicago physician for 53 years, died July 19 at the age of 79. He was on the staff of South Shore Community Hospital and was a member of ISMS Fifty-Year Club.

Dr. Samuel M. Thomas, River Forest, 41, died July 19 in Presbyterian-St. Luke's Hospital where he had been on the staff.

***Dr. J. Frank Waugh,** Seattle, 90, died July 15 at the age of 90. He became internationally known for his early research in the use of X-rays in his treatment of skin diseases including cancer. He was former Superintendent of Children's Memorial Hospital, a member of the Chicago Fifty-Year Club.

*Indicates member of Illinois State Medical Society.

Potassium Loss

In a patient with primary hyperaldosteronism the rates of net transport and of unidirectional fluxes of sodium, potassium, and water in the intact colon were measured before and after removal of that adrenocortical tumor, by perfusing the colon with an isotopically labelled test solution introduced into the cecum through a tube passed by mouth. The results in this patient were compared with those in eight control subjects. Before removal of the aldosterone-producing tumor the colon of the patient secreted potassium at four to five times the rate in control subjects. The undirectional flux of potassium into the colonic lumen was greatly enhanced and the daily loss of potassium in the feces increased. The rates of potassium transport returned to within the range observed in control subjects after the removal of the tumor. (Absorption and Secretion of Water and Electrolytes by the Intact Colon in a patient with Primary Aldosteronism. R. Shields, J. B. Miles, and C. Gilbertson. Birt. Med. Jl. (Jan. 13) 1968; pgs. 93-96.)

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your patient can feel better while she's getting better

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

FRANKLIN COUNTY: Thompsonville; population: 550. Trade area, 1,750. Town without a physician for several years. Nearest at West Frankfort and Benton, 10 and 12 miles. Both towns have hospitals. Office space and housing available. Community would build a new building for an office. Financial assistance if desired. Sources of income: agriculture, mining, and railroads. Churches: Methodist, Baptist. Grade and high schools. Limited recreational facilities. For further information contact: Mr. Troy C. Lager, Clover Leaf Farm, Thompsonville.

FULTON COUNTY: Farmington; population: 3,000. Trade area, 10,000. Two practicing physicians. Third physician died recently, need replacement. Nearest hospital at Canton, 11 miles. Peoria 21 miles. Local prescription drug store. Equipment of deceased physician available if desired. Sources of income: industry, agriculture and mining. Six protestant and Catholic churches. Grade and high schools; Jr. College, 11 miles. Two country clubs at nearby Canton, one at Elmwood. For details contact:

Miss Dorothy Wasson, P.O. Box 257, Farmington. Phone: 245-4615.

FULTON COUNTY: Table Grove; population: 500. Trade area, 3,000. Nearest doctors at Ipava and Astoria, seven and 15 miles. No physician since 1954. Nearest hospitals in Macomb, 17 miles. Peoria 65 miles. Office space and houses available. Financial assistance could be arranged. Agricultural community. Congregational Church. Grade and high schools. Three nearby golf courses. For further information contact: Devere Showden, Clifford Weaver, Wm. Harlan or Don Baily, Table Grove.

GREENE COUNTY: White Hall; population: 3,000. Trade area, 8,000. One physician, age 58. Local hospital 65 miles from Springfield. One prescription drug store. Office space and housing available. Predominant nationality: German. Seven Protestant and Catholic Churches. Grade and high schools. Golf and swimming facilities. Office rent: $95.00 monthly; heat and light furnished. White Hall Hospital used by people from a large area. For details contact Mr. George Stahl, Hospital Administrator, 407 N. Main, White Hall. Phone 374-2121 (area 217).

GRUNDY COUNTY: Gardner and South Wilmington; population: 60,000. Trade area, 4,000. Towns 3 miles apart. No doctor in Gardner; one in South Wilmington. Nearest hospital at Morris, 20 miles. Joliet 35 miles. One drug store. Two doctor Sears Medical facility available. Agriculture and industry area. Four Protestant and Catholic Churches. Grade and high schools. Two golf courses within 10 miles. Chicago loop 75 minutes on Interstate #55. For details contact: Mr. James Small, Gardner, or Rev. Roger Fish, Jr., Gardner. Phone 815-237-8034.

GRUNDY COUNTY: Minooka; population: 700. Trade area, 1,500. Only doctor moved to locate in his wife's home town. Town has supported a doctor for over 65 years. Midway between Joliet and Morris; 4 miles from Route 66 and ½ mile from Interstate 80. No doctor within 10 miles. Joliet 15 miles; population 70,000. Agricultural community. Many residents employed at Caterpillar Tractor. Churches: Catholic and Methodist. Grade and high schools. Nearest golf course 7 miles, swimming pool 12 miles. For further details contact: Mr. Oliver Brinckerhoff, Village Clerk, Minooka. Phone 815-462-5161.



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Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth

MEETING MEMOS

Sept. 19-22—Annual Meeting of the American Medical Writers Association. To be held in Washington, D.C. Theme for the session will be, "National Perspectives in Medical Communications." The newly appointed commissioner of the Food and Drug Administration is one of the nationally known personalities who will take part in the session.

Sept. 28—The International College of Surgeons is sponsoring four consecutive scientific meetings in Honolulu, Hawaii, at which members of the South American Federation, as well as the North American, Central American and Caribbean Federation will take part.

Sept. 30-Oct. 1—AMA is sponsoring the 28th Congress on Occupational Health at the Waldorf-Astoria Hotel in New York City. There is no registration fee for the Congress. The program, featuring 20 different speakers, is acceptable for 11 elective hours by the American Academy of General Practice.

Oct. 3-4—"Protecting the Consumer" will be the theme of this year's National Congress on Health Quackery being sponsored by the AMA and the National Health Council. It will be held in Chicago at the Drake. Advance registration is required. Write to: Joseph A. Sabatier, Jr., M.D., Chairman, Committee on Quackery, 535 N. Dearborn (AMA), Chicago, Illinois 60610.

Oct. 4—ISMS is sponsoring the 11th Conference on Nutrition in Medicine at the LeClaire Hotel, Moline.

Oct. 6—ISMS is sponsoring its Annual Leadership Conference at the St. Nicholas Hotel, Springfield.

Oct. 6—Tokyo, Japan is the site of the Sixteenth Biennial International Congress sponsored by the International College of Surgeons. Dr. Christian Barnard, internationally known heart surgeon, is one of the featured speakers.

Oct. 7-11—The 1968 International Conference on Modern Trends in Activation Analysis. Sponsored by the National Bureau of Standards, the program will provide useful information for those who have no experience in activation analysis and for those who have studied specialized areas in detail. To be held in Gaithersburg, Maryland.

Oct. 10-11—The Fifth Annual Meeting of the Illinois Association of the Professions will be held at the Ambassador Hotel, Chicago. Registration is open to anyone holding membership in IAP.

Oct. 14-18—54th Annual Clinical Congress of the American College of Surgeons. Titled "The Forum on Fundamental Surgical Problems," the meeting will be held in Atlantic City, N.J.

Oct. 14-18—"Who Feeds the Nation," will be the theme of the 51st Annual Meeting of the American Dietetic Association. To be held in San Francisco, the conference will feature recent findings concerning nutrition, diet therapy, food science, food service management and educational techniques.

Oct. 21-25—19th Annual Session of the American Association for Laboratory Animal Science. This session, to be held in Las Vegas, will concentrate on basic animal care and scientific presentations on animal research.

Oct. 28-30—The staff of the Mayo Clinic and the Faculty of the Mayo Foundation are presenting Clinical Reviews. This program is acceptable for credit by the American Academy of General Practice and the College of General Practice of Canada. Those wishing to attend should communicate with M. G. Brataas, Mayo Clinic, Rochester, Minnesota 55901.

Oct. 31-Nov. 2—The American College of Gastroenterology is sponsoring its Annual Course in Postgraduate Gastroenterology. To be held in Boston, Mass. The course will cover the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the esophagus, stomach, pancreas, liver and gallbladder and colon and rectum.

Jan. 6-23, 1969—The Department of Postgraduate Medicine of Albany Medical College is now accepting reservations for the Tenth Medical Seminar Cruise, a 17-day cruise from New York. Faculty of the college will present a comprehensive shipboard postgraduate program, covering subjects in medicine, surgery, pediatrics, obstetrics and gynecology. For more information write: Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

Medicine and Religion

To Better Understand Your Catholic Patient

By Rev. John W. Marren

A close relationship of the Catholic priest and the doctor taking care of the Catholic patient will be very helpful to the patient whether he is in a hospital or under private care.

In the somewhat brief survey this article involves, the importance of the priest and the sacraments of the Church are stressed.

In the spiritual care of the Catholic patient everything is naturally much easier if the priest is from his own parish or from his home town—a priest with whom he has a familiar relationship. But if it is difficult to arrange this, or if this would mean a delay, the patient can be helped by the priest who is chaplain of the hospital or who is from a nearby church. What is important to the Catholic patient is this: he needs a priest because he needs the sacramental ministry of the Church and this will come to him through a priest.

Vatican Council II has stated: "The purpose of the sacraments is to sanctify men, to build up the body of Christ, and, finally, to give worship to God. Because they are signs they also instruct. They not only presuppose faith, but by words and objects they also nourish, strengthen and express it; that is why they are called 'sacraments of faith.' They do indeed impart grace, but, in addition, the very act of celebrating them disposes the faithful most effectively to receive this grace in a fruitful manner, to duly worship God, and to practice charity."

His life as a Catholic begins with his rebirth through Baptism. The sacramental structure parallels his natural life till death in such a way as to elevate its meaning to the supernatural.

Consequently Catholics are very much concerned about the Baptism of their children and will be terribly distressed if one of them should die without Baptism. Realizing this, and making sure that there can be no slipup on this, a doctor will be able to reassure the expectant mother and relieve her anxiety. Even in the event of something like a miscarriage a doctor will be of great consolidation to his patient by making sure of the "conditional" baptism of the fetus. Catholic parents will be grateful to the doctor who will alert them to the dangerous condition of an unbaptized infant so that they will see to the baptism of the child.

In the normal course of life it is the Sacraments of the Eucharist (Communion) and Penance (Confession) that are the sources of spiritual life to the Catholic. Whether the patient is confined to home or is in the hospital he should have the opportunity to receive these sacraments regularly. Not only do we believe that these sacraments will bring about a spiritually healthy condition but we are also convinced that this spiritual condition will be conductive to recovery and better physical health and in this way contribute to the "total health care" we are striving for today.

Too often the relationship of the priest and the Catholic patient has been thought of in terms of "last rites," the Sacrament of Extreme Unction or the annointings and prayers for the dying. The Vatican Council said: "Extreme Unction which may also and more fittingly be called 'annointing of the sick' is not a sacrament for those only who are at the point of death. Hence, as soon as anyone of the faithful begins to be in danger of death from sickness or old age, the appropriate time for him to receive this sacrament has already arrived." In this sacrament the prayers that are said are prayers asking God's help for the recovery of the sick patient. It is the concious patient to whom the priest can be the greatest help.

Often it will be of help to the doctor in dealing with the Catholic patient if he would suggest a visit to a priest or even arrange it. He will find the priest prepared from his educational background to help, especially in the matter of counselling. The doctor learns early in his practice of medicine that many fears are based on hearsay rather than facts. The same is often true of the spiritual difficulties of Catholics with a "spillover" into their state of health. Their "total health" picture will be better for getting the facts from one who can give them.

Clinics for Crippled Children

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will conduct nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicans are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

October 1 Quincy—Blessing Hospital
October 2 Rock Island Cerebral Palsy—Foundation for Crippled Children & Adults, 3808 Eighth Avenue
October 2 Metropolis—Massac Memorial Hospital
October 2 Hinsdale—Hinsdale Sanitarium
October 3 Carrollton—Boyd Memorial Hospital
October 3 Lake County Cardiac—Victory Memorial Hospital
October 3 Cairo—Public Health Building
October 8 East St. Louis—Christian Welfare Hospital
October 8 Peoria General—Children's Hospital
October 9 Champaign - Urbana—Mckinley Hospital
October 10 Rockford—St. Anthony's Hospital
October 10 Flora—Clay County Hospital
October 10 Springfield General—St. John's Hospital
October 11 Chicago Heights Cardiac—St. James Hospital
October 11 Evanston—St. Francis Hospital
October 15 Belleville—St. Elizabeth's Hospital
October 16 Chicago Heights General—St. James Hospital
October 16 Mt. Vernon—Good Samaritan Hospital
October 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
October 17 Bloomington—St. Joseph's Hospital
October 18 Chicago Heights Cardiac—St. James Hospital
October 22 Peoria General—Children's Hospital
October 29 East St. Louis—Christian Welfare Hospital
October 30 Springfield Cerebral Palsy (P.M.)—Diocesan Center
October 30 Aurora—Copley Memorial Hospital
October 31 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

Film Reviews

"Teaching the Mentally Retarded—A Positive Approach" is the title of a film produced by the University of Texas. In black and white, this 16 mm., sound, 23-minute film illustrates the use of a system of teaching based upon rewards or positive reinforcement. It follows the progress made by four severely retarded children during a 4-month training program in which self care—toilet training, dressing, eating—were emphasized. The film illustrates that even the most seriously retarded can learn rather complex skills. Distribution is restricted to agencies and institutions serving the retarded and to professional people trained in the field of mental retardation. The film may be shown to the public for educational purposes if the showing is supervised by a professional person trained in behaviour shaping techniques. It is available on free, short-term loan from the National Medical Audiovisual Center (Annex), Chamblee, Ga. 30005.

* * *

The Texas Institute for Rehabilitation and Research has developed a film available through the Dept. of HEW, Audio-Visual Facility, Communicable Disease Center, Atlanta, Ga. Entitled "Early Detection of Oral Cancer," the color film, running 17 minutes, represents the first major effort to educate the general public on the value of cytological technique for the early detection of oral cancer. The end results of successful treatment are explained.

Now Morton Salt Substitute is making house calls too.

We tested Morton Salt Substitute for 3 years in hospitals across the country. Hundreds of unsolicited letters from patients like yours prove that new Morton Salt Substitute is the first substitute that tastes like the real thing. Because it is, we're willing to put it in grocery stores. Now, salt-free dieters can enjoy it in their homes. If your patients can't have the real thing, let them have the next best thing: New Morton Salt Substitute.





When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
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and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Editorial

(Continued from page 274)

up some experimental models of outpatient practice in an effort to learn how to do our jobs more efficiently, and to meet the critical shortage of physicians projected for the future and indeed, present today. Over and above these considered goals, however, we want to broaden the student's perspective. We want him to begin to see that medicine is no longer an isolated discipline in which a physician can go about seeing individual patients without thinking of the more global aspects of his professional responsibility.

The new physician exists in a society in which there are problems created by population growth, urbanization, and cybernetics. He should realize that he must join his technology to the technology of other disciplines in an effort to work out solutions. He must see the problems of air and water pollution, automobile safety, poor housing with its attendant problems, such as rodents and lead poisoning, as areas in which he has a stake, and in which he can make a significant contribution. As a student recently commented, "It's about time for the surgeon to stop looking at the all too frequent gunshot wounds as simply interesting surgical challenges." Although that is his primary role, he must start to wonder about the problems of society which bring about such violence in our cities.

It seems that this is our job in teaching community medicine, to learn to treat the individual patient with competence, to learn to treat him personally and with respect, and also, to see his problems in terms of the community. This does not make the physician's burden lighter, it makes it heavier; but I submit it provides him with a challenge that can make his life more exciting, more fulfilling and more meaningful than he has ever imagined.

John D. Madden, M.D.
Medical Director
Woodlawn Child Health Center

Prescription drug industry expenditures for research and development during the past 10 years average $7 million per successful new single drug entity, according to the Pharmaceutical Manufacturers Association.

— LETTERS —

To The Editor
Dear Sir:

The ability of physicians to maintain life for very long periods in the unconscious patient raises the question as to how long such skills should be deployed. As physicians we are eager to promote the recovery of everyone who can do so. In order to deprive no one of his chances on this score it is relevant to know the longest periods of coma which have been followed by useful survival.

A committee of the Massachusetts General Hospital is studying our own records and the world literature to determine pertinent features in all patients who, *despite coma for over 5 weeks,* have made a useful recovery. We think it is vital not to overlook any well documented patient in this category. We should be grateful if any reader of this journal would draw our attention to any case published under a title which is not indicative of survival after prolonged coma. We are eager to receive accounts of such cases as yet unreported. A publication incorporating our own and others' data is planned.

We should be grateful if you would publish this letter in your journal either in a section for correspondence, as a special brief communication, or in any other fashion you see fit.

Sincerely yours,
William H. Sweet, M.D., D.Sc.
Chief, Neurosurgical Service
Chairman, Committee on Management of the Unconscious Patient
Massachusetts General Hospital
Boston, Massachusetts 02114
USA

The handicapped worker has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment . . . . Thomas J. Watson, Jr., chairman of the board, IBM Corporation.

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Vitamin B_1	7.5 mg
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Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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Illinois Medical Center Accepts $3,080,340

The University of Illinois Medical Center Campus, Chicago, has accepted an overall total of $3,080,340 in research and training grants for the month of July. Out of 56 grants listed, 45 grants totaling $2,958,989 were from the United States Public Health Service.

The funds were allocated as follows: $387,149, College of Dentistry; $2,064,118, College of Medicine; $215,146, College of Nursing; $4,900, College of Pharmacy; and $409,027, Student Affairs. The largest single grant, $416,500, was awarded to Dr. William J. Grove, dean of the College of Medicine by the United States Public Health Service for "Health Professions Educational Improvement Program."

Mouth Sores May Reflect Underlying Disease

Dentists and doctors who in their practices must make diagnoses involving oral and perioral lesions are reminded that sometimes such sores are more than they seem, in a set of close-up photographs offered by Eaton Laboratories, Division of The Norwich Pharmacal Company. The full-color photos comprise a folder-type brochure, "Oral Manifestations of Systemic Disease." Each photo is printed on an individual card, easy to file or to remove for reference and comparison. Diseases with oral symptoms which are illustrated include tuberculosis, intestinal polyposis, pernicious anemia and acquired syphilis. In the future, Eaton expects to publish additions to the series. Copies of the brochure are available from Eaton's medical sales representatives or by writing to Eaton Laboratories, Norwich, New York 13815.

Hektoen Institute of Medical Research of Cook County Hospital will present a special program of lectures on Wednesday, Sept. 25 in conjunction with its twenty-fifth anniversary. The program, to be held at Hektoen Auditorium, 627 S. Wood St., will include seven distinguished speakers. All are invited to attend.



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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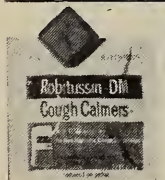
SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 16
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 16
SPECIALTY REVIEW COURCE IN OB-GYN, October 21
SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 28
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, Nov. 18 & Dec. 9
SPECIALTY REVIEW COURSE IN UROLOGY, Four Days, Nov. 18
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
SURGERY OF THE HAND, One Week, September 16
PEDIATRIC SURGERY, One Week, September 30
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept. 23
BLOOD VESSEL SURGERY, One Week, October 7
MANAGEMENT OF COMMON FRACTURES, One Week, October 21
SURGERY OF COLON & RECTUM, One Week, November 11
RADIOISOTOPES, One or Two Weeks, First Monday Each Month
BASIC ELECTROCARDIOGRAPHY, One Week, October 7
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

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A·H·ROBINS

Comprehensive Health Planning

(Continued from page 300)

some shifts in responsibility, for example: with the repeal on June 30, 1967 of Section 318 of the PHS Act, under which *areawide health facility planning* has been conducted heretofore, it has been determined that such special activities are now part of the newly established comprehensive health planning operation; consequently, all applications to support the planning projects for such operations require State Planning Agency review and approval, prior to Public Health Service consideration.

Concluding Remarks on Comprehensive Health Planning

An attempt has been made here to outline some principal features of the effort, beginning with summaries of pertinent legal authorizations contained in the "Partnership for Health" legislation, along with a brief listing of what those of us with special responsibilities for Comprehensive Health Planning have been attempting to do in implementing its provisions. We have also essayed a bit of interpretation apropos the question of Congressional "intent" underlying Public Law 89-749's passage because of its importance to formulation of guidelines for action. As a result, we believe we have something capable of assisting coordinated and well articulated efforts for many facets of health, particular those that over the last few decades have become objects of federal support. We also note in the legislation considerable emphasis given to an expanded role for local areas, thereby enabling optimum participation in selection of priorities at that point where all such health programs have their ultimate impact. On the whole, therefore, we feel reasonably secure in viewing such developments as indicative of a healthy trend, one needed if we are to form a truly effective "Partnership" in this complex field.

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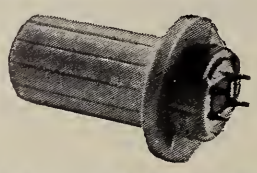
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Refresher Courses

Over 150 Illinois physicians have taken advantage of the Medical Refresher Course sponsored by the Division of Professional Services of the State of Illinois Department of Mental Health.

The program, designed to prepare physicians holding State Hospital Permits (Illinois Temporary Licenses) for the Illinois Physicians and Surgeons Licensure Examination as well as for the test required by the Educational Council for Foreign Medical Graduates, has been in operation for two years. It is under the direction of Alexander A. Kaluzny, M.D.

Six complete courses have been given by the Department since the program's inception in October, 1966, covering 17 different areas including biochemistry, physiology, internal medicine, clinical medicine, surgery and sub-specialties, pediatric and pediatric surgery, orthopedic and traumatology and obstetrics.

The first two courses were conducted concurrently in Chicago between October 1966-June 1967. One of these was held at the Chicago State Hospital and was attended by 32 physicians. At the same time another course was given at the Illinois State Psychiatric Institute for physicians located within driving distance of Chicago; 47 physicians attended this session.

Additional courses have been conducted in Peoria at the George A. Zeller Zone Center and at the Manteno State Hospital. A second course has also been conducted at the Chicago State Hospital.

In an effort to offer a similar Medical Refresher Course to physicians in southern Illinois, the sixth and most recent session began last March in St. Louis. This course, which is being conducted in conjunction with Washington University and the microbiology, pharmacology, pediatrics and neurology departments of St. Louis University, will be completed in September, 1968. Thirty-two physicians are enrolled. Participants include members from Alton State Hospital, Anna State Hospital, Jacksonville State Hospital, Warren Murray Children's Center and the Mount Vernon Tuberculosis Sanitarium.

Active participation suggests that additional Medical Refresher Courses will be sponsored by the Department of Mental Health in the near future.

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Information about the program may be obtained from Charles H. Jones, M.D., Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093, Telephone: (312) 446-8440

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Vol. 2, No. 10 October, 1968

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ASK BLUE SHIELD

• • • ABOUT MEDICARE

The following articles, published previously in issues of this Report, are being reproduced in answer to many questions we have received regarding assigned Medicare claims and payments made to beneficiaries on itemized statements.

Payment on Itemized Bill

A physician who does not accept an assignment and submits an *itemized bill* to his Medicare patient, should include on each bill the patient's name; the physician's name; the date, place, description of EACH service provided and the charge for EACH service. Unusual circumstances or complications should be described if they are reflected in the charge. This information is needed before payment can be made to Medicare patients for covered services.

The 1967 Amendment to Social Security which allows a payment to be made on an *itemized* rather than a receipted bill is intended to provide the Medicare patient with the resources to help pay his physician's charges. *But, it also increases the possibility of duplicate payment being made for the same service.* It is possible, for example, for a physician to accept an assignment at the same time his patient submits an itemized bill for payment.

A physician who accepts an assignment will not be paid when the benefit has already been paid to his patient. Likewise, no payment will be made to his patient when the benefit has been paid to the physician.

When a Medicare patient's claim is received first, payment will be made to him. When a claim from a physician who accepts an assignment is received before payment is made to his patient, payment will be made to the physician.

Therefore, physicians who do accept assignments should submit claims promptly for services they have provided. And to reduce the possibility of duplicate claims from being filed or duplicate payments from being made, they should clearly indicate on their patient's bills that they accept assignment.

The AMA on Itemized Bill

At its clinical meeting in Houston, the House of Delegates of the American Medical Association adopted a report of the Board of Trustees, with amendments, which emphasized the responsibilities of physicians and medical societies when physicians bill their Medicare patients directly.

The position taken by the AMA House is as follows:

1. "The physician must report fully and specifically in his billing the nature of the services provided so that the patient may be properly reimbursed by the Medicare carrier and should guide his patient in his application for reimbursement.
2. The physician should adhere to his usual, customary, and reasonable charges.
3. Much of the misunderstanding about direct billing may be eliminated if the physician and the patient will discuss in advance the fee, and that portion of it which will be reimbursable through Medicare and that portion which will remain the responsibility of the patient.
4. The physician should explain to the patient that Medicare is not a full-paid plan; and that the patient should anticipate paying part of the fee as clearly spelled out in the law. Physicians whose usual fees exceed those which are customary in their medical area should explain in advance to their patients the effect this will have on Medicare payments.
5. Local Medical Societies should provide review mechanisms which are made freely available to the public:
   (1) To insure that the interests of patients are protected in dealing with Medicare carriers;
   (2) To advise all parties as to the propriety of fees which may be charged by physicians."

Patient's Signature on Assigned Claims

Some patients have challenged assigned payments to physicians, especially hospital-based physicians, stating that they did not make an assignment. It is therefore necessary that we have the patient's signature on *all* assigned claims unless a blanket SSA 1490 has been submitted for the same illness. The physician treating a patient over an extended period of time need not obtain the patient's signature each time he accepts an assignment. However, he can obtain the patient's consent to an assignment of unpaid charges for the anticipated period of treatment by having the patient sign a brief statement as follows: "I request that payments under the medical insurance program be made directly to Doctor_____ on any unpaid bills for services furnished me by that physician during the period _____ to _____." When the physician submits the 1490 for payment on which he accepts an assignment, he should indicate in the patient's signature space "This is a continuation of a course of treatment for which patient's assignment was previously obtained."

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Pink Puffers and Blue Bloaters

It is usually possible to separate most patients with severe obstructive pulmonary disease into two clinical categories—the Pink Puffers and the Blue Bloaters. According to Scadding[1] the terms 'Blue Bloater' and 'Pink Puffer' originated with Dr. A. C. Dornhorst of St. George's Hospital in London. To quote Dr. Scadding, "The Blue Bloaters are most characteristically those who have started with long continued chronic bronchitis punctuated by recurrent inflammatory episodes. After many years these episodes are accompanied by alveolar hypoventilation and cyanosis, carbon dioxide retention with associated disorders of consciousness often made worse by oxygen, and edema and raised jucular venous pressure. With appropriate treatment they may survive several of the episodes of edema to which the term 'Bloater' refers. In such patients emphysema may not be a prominent feature at necropsy although during life severe airway obstruction is found."

"The Pink Puffer, considerably less frequent in England, is the type of patient who starts with progressive dyspnea on exertion, usually in middle age, without a preceding history of chronic bronchitis. He has overdistended lungs, often curiously silent to auscultation. In spite of a much reduced ventilatory capacity with considerable irreversible airway obstruction and greatly increased residual capacity, he nevertheless manages to maintain a minute volume above that of a normal subject at rest and so keeps his PCO_2 down to normal levels until very shortly before the end of his disease. Moreover, he develops right ventricular failure, if at all, only terminally, very rarely making a useful functional recovery once edema has appeared. Such patients may confidently be expected to show emphysema at necropsy." (William B. Hunt, Jr., "Criteria for Diagnosis of Asthma, Chronic Bronchitis and Emphysema, With a Note on Pink Puffers and Blue Bloaters." **Virginia Med. Monthly** [Feb.] 1968; **95**; pg. 73.)

References

1. J. C. Scadding, Meaning of Diagnostic Terms in Broncho-Pulmonary Diseases. Brit. M.J. 2: 1425-1430, 1963.

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Meeting July 20-21, 1968

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

DR. THOMSEN MEETS WITH NURSES

Dr. Thomsen, ISMS president, and Dr. Jirka, Chairman of the Board, reported that they had attended and taken part in a meeting held with representatives of the nursing profession. They stated that the nurses desired to establish a better rapport with the ISMS and desired the cooperation of the doctors in the many things they were being asked to do, particularly regarding emergency room care. Also discussed were the Nurse's activities in the intensive care treatment of coronary case patients. Further report and recommendation will be forthcoming.

APPROVAL OF HANDBOOK ON MEDICAL CERTIFICATION

The Illinois Department of Public Health, Division of Vital Statistics, asked for approval of the contents of a proposed physician's handbook on medical certification. The ISMS Committee on Vital Statistics reviewed the manual and several suggestions for its improvement were adopted. The committee recommended approval of this handbook based upon a careful review of the contents. As recommended by the Executive Committee the Handbook was approved.

LACK OF COUNTY HEALTH CENTERS CITED

Dr. Yoder, Illinois Director of Public Health, commented on the distribution of local health departments throughout the State, calling special attention to the counties where there were no local health centers organized. The ISMS should help establish a local health department whenever possible and then participate to set the policies for their activities. The Board voted to support the Health Department's campaign for developing additional county health departments.

HOSPITAL LAB SERVICES

Counsel asked Dr. Yoder to comment on the use of hospital laboratories by chiropractors, calling attention to the legal ramifications of this practice. Dr. Yoder indicated that he first needed to know from legal counsel whether there was anything they could do by regulation. If so, they were certainly willing to try. Dr. Yoder stated that his Department would be glad to cooperate with the State Medical Society. Mr. Pfeifer indicated his belief that hospital laboratories should adopt a rule to the effect that they would only make examinations for those persons who used the results in their practice. It was his recommendation that contact be made with the Health Department and the possibility of establishing such a rule considered.

ABILITY TO PRACTICE OPINION

Mr. Pfeifer, legal counsel, reported as to what actions a county medical society could take regarding an incompetent physician. He stated that the county society, or even the state society, had no power to hold a hearing or to revoke or suspend a license—this was entirely within the purview of the Department of Registration and Education. On the other hand, the local society had the power and certainly the moral obligation, in the event an incompetent individual practiced in the area, to make a discreet investigation, and report to the state society. He further indicated that the Department of Registration and Education was attempting to do a better job in this field and had asked for cooperation from the state society.

TESTIMONY FOR DEPARTMENT OF REGISTRATION AND EDUCATION

A letter from the Department of Registration & Education has been received soliciting cooperation of the state society with regard to medical testimony. It was suggested the procedure to be followed in this event be as follows: when the Department of Registration has a problem where they feel that they do need medical testimony, that they notify the State Society and then in turn, the state society contact the local society where the individual concerned was a member, and attempt to obtain additional information from him. In the event medical testimony should be warranted, the state society would attempt to provide the Department of Registration & Education Division with the names of physicians who might be willing to testify and the Department could contact these physicians. This matter will be investigated and pursued further for report to the Board.

MEDICARE AND IDPA ASSIGNMENTS IN CLARK COUNTY

Doctors in Clark county have not been accepting assignments in relation to Medicare patients jointly eligible for payments under Public Aid. This position is backed by both the House of Delegates and by the action of the ISMS Advisory Committee to the IDPA and also, in principle, by the Usual & Customary Fees Committee of the Society. Board approval was requested for setting up a testing area in Clark County in cooperation with the Department of Public Aid and the Social Security Administration.

The Clark County procedure would call for the Department of Public Aid to pay the annual $50 Medicare deductible. Medicare would pay the doctor the usual 80% of the allowable charge without the requirement for an assignment. The physician would write off the balance as a charitable service. This request for a test area was granted and it was suggested that a report be presented to the House of Delegates at its next meeting.

(Continued on page 581)

The president's page



Philip G. Thomsen, M.D.

As we study your vigorous response to the ISMS Survey on Major Issues that you received in August, one basic result already is clear:

You have given us plently of grist for constructive programs and action in the weeks ahead.

About 3,000 of you answered the survey —a total that is all the more remarkable in a top vacation month like August. Some of you offered thoughtful observations and ideas below your checkmarks. Your eager cooperation on this project will stimulate us to serve you better.

Dr. Matthew B. Eisele, chairman of our Committee on Public Relations, will analyze the results in the November, December and January issues of IMJ. The series will be divided into legislative, socio-economic and professional topics.

Curiousity has prompted me to make a little analysis of my own. I compared some results in terms of the age brackets you marked on the survey's last page.

On some questions, the opinions of young and old were almost identical. But a notable difference occurred on this question:

"To relieve the shortage of G. P.'s, should the ISMS demand two to three years of general practice as a prerequisite to specialized training?"

Answering "yes" were 57 percent of the physicians over 55 years old, but only 37 per cent in the 40-55 bracket and 22.1 per cent in the under-40 group. Since more than half the doctors answering that question are in the 40-55 group, the "yesses" averaged out at 41 per cent.

But on the question of payments under Medicare, general satisfaction was expressed by 65 per cent in both the under-40 and over-55 bracket—and by 68 per cent in the 40-55 group.

Please study the complete survey analyses in the coming IMJ issues. Meanwhile examine this Reference Issue—and hold on to it. Within its covers you'll find the most significant details on the structure of professional medicine in Illinois. You'll see who is doing what . . . which committee or agency is responsible for a particular facet of medicine . . . and similar information. I know this issue will serve you constantly and well.

Philip G. Thomsen M.D.

no gag



IMJ
Illinois Medical Journal

volume 134, number 4 October, 1968

ISMS ORGANIZATION

History of Founding and Expansion

TWENTY-NINE PHYSICIANS met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

LIST OF OFFICERS AND PLACES OF MEETING SINCE ORGANIZATION OF THE SOCIETY

Year	President	Secretary	Treasurer	Meeting Place
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy

Year	President	Secretary	Treasurer	Meeting Place
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeiffenberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center* (Past President-Elect)			
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago

*Died before induction into office
**Died in office. Term completed by Robert S. Berghoff, First Vice President
***Meeting cancelled 1945

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Constitution And Bylaws
May 1968

Adopted, 1903
As Amended, 1968

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, sixteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.*

A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.

(1) *Distinguished Members.* Distinguished members shall be:

a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or

b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
c. Members of associated arts or sciences who have made significant contributions to medicine.

(2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.

(3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

Section 2. *Qualifications for Membership.*

A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a graduate of a medical school approved in the United States or Canada, a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.

B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. The following shall also be eligible if approved and recommended by the component medical society:

(1) Every physician serving as a full time employee at the headquarters of the American Medical Association;

(2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress;

D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member to be elected to emeritus membership shall:

(1) currently be in good standing,
(2) have been a member in good standing for 35 years,
(3) have reached, or will have reached before the next fiscal year, the age of 70 years, and
(4) have made written application to and have been recommended by his component society for emeritus status.

Such membership shall become effective January 1 of the year following election. Emeritus members shall have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school approved in the United States or Canada, who is of good moral character and professional standing and who is serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal.

Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.

Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school approved in the United States or Canada, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

Section 7. *Tenure of Membership.* The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

Section 8. *Withdrawal of Privileges.* No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

CHAPTER II. ANNUAL CONVENTIONS

Section 1. *Date.* The Board of Trustees shall determine the date for the annual convention.

Section 2. *Meeting Place.* The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and approval by the Board of Trustees.

Section 3. *Scientific Meetings.*

A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.

B. For the transaction of scientific business, there shall be one or more sections as may be determined from year to year by the Board of Trustees.

C. Section officers shall be appointed by the president of the Society from nominees recommended by the section, or if there are no nominees, from a list submitted by the chairman of the Committee on Scientific Assembly.

D. The officers of the sections shall arrange the scientific program for the section in cooperation with the Committee on Scientific Assembly.

E. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.

F. The general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.

G. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

H. The Board of Trustees shall be entirely responsible for the annual convention.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of:

(1) Delegates elected by the component societies
(2) The president
(3) The president-elect
(4) The secretary-treasurer
(5) The speaker of the House (or the vice speaker when presiding) and
(6) The trustees.

Non-voting members shall be the vice presidents, the vice speaker (when not presiding), the past trustees, past speakers, past presidents, general officers of the AMA and delegates from the Illinois State Medical Society to the AMA.

Section 2. *Meetings.* The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Society. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

Section 3. *Quorum.* Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

Section 4. *Special Meetings.* Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 5. *Delegates.* Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof; but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by

the number of active members of the component society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

Section 6. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified by his county society and so certified to the secretary of the Illinois State Medical Society.

When a delegate and his alternate are unable to attend a specified meeting, the appropriate authorities of the component society concerned may appoint a substitute delegate and a substitute alternate who on presenting proper credentials, shall be eligible to regular membership in the House of Delegates.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that meeting. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced.

Section 7. *AMA Delegates and Alternate Delegates.* The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 8. *District Divisions.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Committees.* The House of Delegates may authorize the appointment of ad hoc committees by the president, who shall first consult with the president-elect.

The president shall have authority to designate to serve on ad hoc committees, members of the Society who are not members of the House and who may be present and permitted to participate in the debate when the report of the committee is considered.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, sixteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER V. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

He shall preside at the general scientific meetings of the Society or designate one of the vice presidents to substitute for him.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the president shall fill the office by appointment.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual con-

vention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint the reference committees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, resignation or inability of the speaker to perform his duties, the vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

The secretary-treasurer shall give bond in such sum as may be fixed by the Board of Trustees, the premium on such bond to be paid by the Society. He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VI. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of sixteen trustees elected by the House of Delegates [six shall be chosen from district number three, and one from each of the other ten districts (see map attached), these districts of the geographical area as of May, 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and secretary-treasurer.

The vice presidents and vice speakers shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He

shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

C. *Committees.* The Board shall form the following committees within itself:

(1) Executive Committee
(2) Finance Committee
(3) Policy Committee
(4) Ethical Relations Committee
(5) Committee on Committees
(6) Committee on Constitution and Bylaws
(7) Journal (Publications) Committee
(8) Advisory Committee to Woman's Auxiliary
(9) Such others as deemed necessary.

D. *Duties of the Committees.*

(1) *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer and the trustee-at-large.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(2) *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee. It shall:

(a) Examine applications to the Society for assistance to determine eligibility for assistance.
(b) Keep the names of the beneficiaries confidential and known only to the committee.
(c) Recommend to the Finance Committee the allotment for each recipient, and
(d) If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

(3) *Policy Committee.* The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society.

(4) *The Ethical Relations Committee.* The Ethical Relations Committee shall be Constituted and function as stipulated in CHAPTER XII. DISCIPLINE. Part 2 Illinois State Medical Society procedures, Section 7.

(5) *The Committee on Committees.* The Committee on Committees shall review annually the purpose, activity and structure of all committees, and shall recommend such changes in existing committees or propose such additional committees as appear to be required for the efficient conduct of the business of the Society.

The activities of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

(6) *The Committee on Constitution and Bylaws.* The Committee on Constitution and Bylaws shall:

(a) Receive from individual members, county societies, committees, the Board of Trustees,

and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

(b) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

(c) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

(7) *The Journal Committee.* The Journal Committee shall be composed of members of the Board of Trustees, and shall be responsible for the production of the Illinois Medical Journal.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

(8) *Advisory Committee to the Woman's Auxiliary.* The Advisory Committee to the Woman's Auxiliary shall consist of the president elect as chairman, the president and the chairman of the Board of Trustees.

The Committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

Section 6. *Quorum.* Ten members of the Board of Trustees shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of the district Ethical Relations Committee, Grievance Committee, and Prepayment Plans and Organizations Committee. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and

cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Grievance Committee, a Committee on Prepayment Plans and Organizations, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected, subject to the general rules on composition of committees contained in Section 5, Chapter IX, of these Bylaws, at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

CHAPTER IX. COMMITTEES

Section 1. *Committees of the Illinois State Medical Society.* The committees of the Illinois State Medical Society shall be:

A. Standing committees called Councils
B. Reference committees
C. Ad hoc committees
D. Board of Trustees committees

Section 2. *Standing Committees-Called Councils.* The standing committees of the Society shall be:

A. The Judicial Council
B. The Council on Scientific Services
C. The Council on Legislation and Public Affairs
D. The Council on Public Relations
E. The Council on Medical Education
F. The Council on Medical Service; and such other Councils as shall be established from time to time by the Board of Trustees.

Section 3. *Organization of Councils.*

A. Councils shall be appointed by the Board of Trustees.
B. The chairman of a Council shall be designated by the Board.
C. Each Council shall have authority to request the Board of Trustees to appoint sub-committees for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of the sub-committee.
D. These sub-committees may also request the Board to appoint special committees for any purpose relating to the general functions of the sub-committee. A member of the sub-committee shall chair the special committee.
E. Only active members of the Illinois State Medical Society, not American Medical Association delegates nor those holding elective office in the Illinois State Medical Society, may be appointed to a Council. Any active member of the State Society may be a member of a sub-committee or a special committee. Elective officers may be appointed advisors to any committee.

Recommendations for membership on any

committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

F. Each Council, sub-committee or special committee shall have authority to make rules to govern its procedures subject to:
   (1) Specific requirements of the Constitution and Bylaws and the policies of the House of Delegates, and
   (2) Approval of the Board of Trustees.

G. Each Council shall submit for adoption, a budget for the ensuing year, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

H. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members of the various Councils, and may attend all committee meetings.

I. Each Council shall have members in sufficient quantity so that each sub-committee may be chaired by a different member.

J. Terms of office of members of the Councils shall not be more than three years, but may be terminated for cause at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

K. *Reports.*
   (1) Special committee reports shall be made by the chairman to the sub-committee from which he was appointed.
   (2) Reports from sub-committees (which shall contain summaries of the report of special committees) shall be made by the chairman to the Council of which he is a member.
   (3) Reports of Council activities shall include recommendations on reports and requests from sub-committees, and shall be made to the Board of Trustees by the chairman of the Council.
   (4) The Chairman of the Council with the approval of the Board, may permit any member of a committee under the Council to clarify the report of that committee to the Board.
   (5) The Chairman of any committee may request the Board of Trustees to allow him, or any member of his committee, to appear before the Board.
   (6) All committees shall submit to the House of Delegates, written reports summarizing all actions, and may include recommendations for House consideration.

L. Vacancies on any committee may be filled at any time by the Board of Trustees. Committee membership may be enlarged or decreased or the committee may be discharged by the Board of Trustees.

M. *Committee Meetings*

The chairman of a committee, when he considers it expedient and with the consent of two thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members.

Section 4. *Duties*

A. *The Judicial Council*

The Judicial Council shall:
   (1) Investigate
      (a) Controversies arising under this Constitution and Bylaws and under the principles of medical ethics, to which the Society is a party, and
      (b) Controversies between two or more county societies and their members.
   (2) Investigate all questions of medical ethics and the interpretation of the Constitution, Bylaws and Policies of the Society.
   (3) Investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public.
   (4) Receive appeals filed by applicants who allege that they have been denied membership in a component society because of race, creed, color, or ethnic origin, to determine the facts of the case and to report the findings to the Board of Trustees.

B. *The Council on Scientific Services.* The Council on Scientific Services shall:
   (1) Encourage and assist in the development of community programs designed to maintain, protect and improve the health of residents of the state of Illinois.
   (2) Cooperate with the Illinois Department of Public Health in the control and prevention of contagious diseases.
   (3) Formulate and participate in programs designed to decrease occupational, environmental and physical hazards.
   (4) Recommend and promulgate standards

for ancillary medical services and laboratories.

(5) Participate and advise in programs designed to reduce morbidity and mortality in diseases peculiar to any segment of the people of Illinois.

(6) Work for the establishment of measures for the control of hazardous drugs and agents.

(7) Develop and support legislative measures to accomplish these aims.

C. *The Council on Legislation & Public Affairs.*
The Council on Legislation and Public Affairs shall:

(1) Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens in Illinois and the practice of medicine in Illinois.

(2) Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.

(3) Cooperate with the AMA in similar programs.

(4) Shall develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

D. *The Council on Public Relations*
The Council on Public Relations shall plan and execute programs designed to enhance the relationship between the public and the medical profession.

E. *The Council on Medical Education*
The Council on Medical Education shall:

(1) Study and evaluate all phases of medical education including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians.

(2) Study and evaluate education relating to the health professions and services important to medicine, including the development of programs approved by the House of Delegates, for the provision of a continuing supply of well-qualified personnel in these fields.

(3) Carry to the deans of the medical schools recommendations from the viewpoint of the practicing physicians.

(4) Study, evaluate and criticize the post-graduate programs of the Society and other organizations.

(5) Be available to advise and cooperate with the Department of Registration and Education of the State of Illinois.

(6) Organize, coordinate and administer the scientific sessions of the Illinois State Medical Society subject to the regulations outlined in these Bylaws, especially those in CHAPTER II, Annual Conventions. Section 3. Scientific Meetings.

F. *The Council on Medical Service*
The Council on Medical Service shall:

(1) Coordinate committee activities, avoid duplication in over-lapping of projects, close gaps in medical service programming and serve as a catalyst in activating new committee programs.

(2) Initiate, explore and bring to the attention of the Board of Trustees suggested new policies and philosophies relating to medical service in Illinois.

(3) Serve as an advisory body to allow for the interchange of ideas between various committees of the Council.

(4) Consult with Council members as chairmen of committees with similar aims and objectives.

(5) Advise the staff in socio-economic issues and further the health and welfare of the public by seeking continuous improvement of medical service in Illinois.

(6) Establish liaison with other Councils of organized medicine, including those of the AMA.

(7) Provide a channel of communication between the Illinois State Medical Society and the federal health agencies, the health insurance industry, the Blue Cross-Blue Shield Plans, and similar organizations in matters of mutual concern.

Section 5. *Reference Committees*
Reference Committees shall be appointed by the speaker of the House of Delegates as outlined in Chapter X. REFERENCE COMMITTEES, and as provided therein.

Section 6. *Ad hoc Committees*

A. Ad hoc committees shall be appointed by the speaker of the House of Delegates to accomplish specific duties.

B. Any member of the Society may be asked to serve.

C. The terms of appointment shall be for the duration of the task, or until the committee shall be discharged.

D. Ad hoc committees expected to serve for more than three years, shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council and should be appointed by the Board of Trustees.

E. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees keeping it informed of all current activities.

Section 7. *Board of Trustees Committees*
These committees are detailed in CHAPTER VI. THE BOARD OF TRUSTEES Section 5 (D).

CHAPTER X. REFERENCE COMMITTEES

Section 1. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

Section 2. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

Section 3. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 4. *Reference Committees.* The following committees are hereby provided for:

A Committee on Credentials
A Committee on Rules and Order of Business
Tellers and Sergeants-at-Arms
A Committee on Changes in the Constitution and Bylaws

and such other committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

Section 6. *A Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

Section 7. *The Tellers and Sergeants-at-Arms* shall

A. Serve the speaker of the House of Delegates
B. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required
C. Certify those in attendance in closed or executive sessions of the House of Delegates.

Section 8. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee of the House of Delegates.

CHAPTER XI. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes

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and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the fifteenth of January each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XII. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

The component society (or district) Ethical Relations Committee may employ legal counsel. Such committees may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or

B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:

(1) of a gross misconduct as a physician or surgeon, or

(2) of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society should be referred directly to the secretary of the component society of which the accused is a member and to the appropriate district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. An accused is presumed to be innocent until he has been proven guilty.

B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.

C. After formal charges have been preferred there shall be no evasion of the fact that the respondent is to be tried; that the Ethical Relations Committee before which he is cited to appear is a trial body and that he will be on trial when he appears.

D. He must be notified by certified mail of the

specific charges which are made against him at least ten days before the date set for his trial.

E. He may not be found guilty of anything not included in the charges preferred against him and presented to him.

F. All evidence not pertinent to the charge as made shall be considered irrelevant and immaterial . . . it shall be wholly disregarded in the decision.

G. Testimony not bearing on the charges shall be objected to and if sustained by the trial body, stricken from the records.

H. The respondent shall be advised of his rights by the trial body, namely: (1) that he may be represented by any member of the society as counsel and/or by legal counsel; (2) that he or his counsel may cross examine witnesses; (3) that he may offer in evidence any records or documents that he deems fit; (4) that he may enter objections as to testimony or to material offered in evidence; (5) that he may address the trial body in his own behalf; (6) and that he has the right of appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS ten days prior to the date the appeal is to be heard. Failure to provide such records shall be grounds for a verdict of default against the component society.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 7. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

It shall serve as an appellate body to review cases involving these matters referred by component medical societies, and shall consider matters of law (ethics) and procedure.

Section 8. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. Appeals must be accompanied by pertinent data and transcripts indicating the basis for the appeal. Failure to provide such data shall be grounds for a verdict of default against the plaintiff. The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 9. *Verdict.* On conclusion of the hearing, the Ethical Relations Committee of the Board of Trustees shall meet in executive session to consider its decision, and shall report in writing to the Board at its next meeting for approval or rejection.

Section 10. *Notification of Parties.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board.

A. *Right of Appeal to the American Medical Association.* In case of findings against the accused, and in support of the action taken by the component society, the secretary of the state society shall notify the accused within ten days by certified mail of his right to appeal to the Judicial Council of the American Medical Association.

B. *Error.* In the event of a decision by the Board of Trustees of improper law (ethics) and/or procedure by the trial body of the component society, the case shall be remanded with recommendations to the component society for reconsideration.

CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

Section 2. Robert's "Rules of Order, Revised." shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

Order of Business of the House of Delegates

FIRST SESSION

1. Call to order.
2. Report of Committee on Credentials.
3. Roll Call.
4. Reading and approval of minutes of last meeting.
5. Appointment of Reference Committees.
6. Reports of Officers.
7. Reports of the Trustees, the Editor, etc.
8. Reports of Standing Committees.
9. Reports of Board Committees.
10. Reports of Special Committees.
11. Reading of Resolutions.
12. Unfinished Business.
13. New Business.
14. Recess.

LAST SESSION

1. Call to order
2. Report of Committee on Credentials
3. Roll Call
4. Reports of Reference Committees
5. Fixing of per capita tax for ensuing year
6. Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
7. Unfinished business
8. Election of
   (a) officers
   (b) trustees
   (c) delegates to the AMA
   (d) alternate delegates to the AMA
9. Induction of President Elect into the office of President
10. New business
11. Adjournment (sine die)



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Policy Manual of the Illinois State Medical Society May 1967

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys (Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Autonomy of County Medical Societies

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Cultists, Association with (Association with Osteopaths—see "0")

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the Illinois Medical Journal as a part of the annual report of the chairman of the Board.

Education

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance pro-

gram which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies (also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Assessments—See Assessments

Hospital Committees (Dealing with physician-patient relationship)

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

House of Delegates, Special Meetings of

When a special meeting of the House of Dele-

gates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Fixed fee schedules should not be accepted. All fees should be based upon the usual and customary fee concept.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Journal (Publications) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the Illinois Medical Journal.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Lay Employees and Their Prerogatives

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy
- establish new policy
- request House approval of committee projects and/or
- procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Legislative Committee for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Legislation of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Legislation, which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Legislative Council primarily should consider relationship of the proposed legislation to the total legislative program.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the

appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion HAS BEEN expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material for publication in the Illinois Medical Journal, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

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President: Laszlo Koos
13000 Maple Ave., Blue Island 60406
Secy.-Treas.: John E. Driscoll
18109 Dixie Hwy., Homewood 60430

Stock Yards Branch
President: Glenn A. Burckart
11110 S. Sawyer, Chicago 60655
Secy.-Treas.: Edwin J. Lukaszewski
1213 W. 51st St., Chicago 60609

West Side Branch
President: Eugene T. Hoban
6429 W. North Ave., Oak Park 60302
Secy.-Treas.: Anna A. Marcus
5852 W. North Ave., Chicago 60639

CHRISTIAN COUNTY
President: F. W. Siegert
217 Locust St., Pana 62557
Secretary: J. W. Murphy
301 S. Webster St., Taylorville 62568
Members: 19—District No. 7

CLARK COUNTY
President: Eugene P. Johnson, Casey 62410
Secretary: Charles C. Moore, Jr.
Martinville Clinic, Martinville 62442
Members: 6—District No. 8

CLAY COUNTY
President: William T. Kamp
433 E. 7th St., Flora 62839
Secretary: Donald L. Bunnell
433 E. 7th St., Flora 62839
Members: 8—District No. 7

CLINTON COUNTY
President: W. R. Ketterer
289 Main St., Breese 62230
Secretary: J. Roger Sosa
Munster St., German Town 62245
Members: 11—District No. 7

COLES-CUMBERLAND COUNTY
President: Charles E. Ramsey
Midwest Prof. Bldg., Charleston 61920
Secretary: G. D. Wright
1517 University Ave., Charleston 61920
Members: 39—District No. 8

Crawford County
President: Charles Salesman
1201 N. Allen, Robinson 62454
Secretary: W. B. Schmidt
306 S. Cross, Robinson 62454
Members: 14—District No. 8

De Kalb County
President: Thomas deGraffenried
DeVal Shopping Center, De Kalb 60115
Secretary: Frank E. Luedtke
232 Second St., De Kalb 60115
Members: 47—District No. 1

De Witt County
President: John W. Veirs
219 E. Main, Clinton 61727
Secretary: Charles Ramey
215 E. Main, Clinton 61727
Members: 11—District No. 5

Douglas County
President: James Taylor
102 N. Main, Villa Grove 61956
Secretary: Elmer Allen
120 S. Locust, Arcola 61910
Members: 13—District No. 8

Du Page County
President: William E. Hill
201 W. Union St., Wheaton 60187
Secretary: Charles A. Lang
646 Roosevelt Rd., Glen Ellyn 60137
Executive Secretary: Lillian Widmer
646 Roosevelt Rd., Glen Ellyn 60137
Members: 339—District No. 11

Edgar County
President: C. A. McClelland
502 Shaw Ave., Paris 61944
Secretary: J. M. Ingalls
502 Shaw Ave., Paris 61944
Members: 16—District No. 8

Edwards County
President: Paul S. Neirenberg
7 W. Main St., Albion 62806
Secretary: Andrew Krajec
Box 336, West Salem 62476
Members: 2—District No. 9

Effingham County
President: H. F. Webb
300 N. Maple, Effingham 62401
Secretary: Nicholas Beck
300 Millsprings, Greenup 62428
Members: 24—District No. 7

Fayette County
President: J. H. Weiner
503½ Gallatin, Vandalia 62471
Secretary: E. A. Kuehn
Greer Bldg., Vandalia 62471
Members: 9—District No. 7

Ford County
President: Clyde Rulison, Roberts 60962
Secretary: William Garrett, Sibley 61773
Members: 12—District No. 11

Franklin County
President: C. H. William
108 N. Benton Rd., W. Frankfort 62896
Secretary: D. L. Griffin
R. D. No. 1, W. Frankfort 62896
Members: 22—District No. 9

Fulton County
President: Julius Manber
Graham Hospital, Canton 61520
Secretary: O. M. Wood, Ipava 61441
Members: 26—District No. 4

Gallatin County
President: Joe Bryant, Ridgway 62979
Secretary: John Doyle, Ridgway 62979
Members: 3—District No. 9

Greene County
President: Jude A. Castelton
419 N. Main St., Carrollton 62016
Secretary: A. K. Baldwin
229 N. Fifth St., Carrollton 62016
Members: 10—District No. 6

Hancock County
President: Irving Burnell
861 S. State St., Augusta 62311
Secretary: Ilse Erika Bruehsel, Warsaw 62379
Members: 10—District No. 4

Henderson County
President: Elmer Swann, Oquawka 61469
Secretary: Harold L. Bock, Stronghurst 61480
Members: 3—District No. 4

Henry-Stark County
President: Andrew E. Skladany
1202 Fourth St., Orion 61273
Secretary: Fred V. Colby
213 W. First St., Geneseo 61254
Members: 34—District No. 4

Iroquois County
President: R. K. Swedlund
112 N. Fourth St., Watseka 60970
Secretary: C. L. Clark, Sheldon 60966
Members: 19—District No. 11

Jackson County
President: O. Ballesteros
215 N. 14th St., Murphysboro 62966
Secretary: Homer H. Hanson
404 W. Main, Carbondale 62901
Members: 52—District No. 10

Jasper County
President: Don Hartrich
Box 192, Newton 62448
Secretary: C. O. Absher, Newton 62448
Members: 4—District No. 8

Jefferson-Hamilton County
President: Morris Zelman
117 N. 10th, Mt. Vernon 62864
Secretary: H. Goff Thompson, Jr.
320 N. 9th St., Mt. Vernon 62864
Members: 23—District No. 9

JERSEY-CALHOUN COUNTY
President: Clyde L. Wieland
300 S. Washington, Jerseyville 62052
Secretary: Victor Oberheu
306 S. Washington St., Jerseyville 62052
Members: 9—District No. 6

JO DAVIESS COUNTY
President: David Hockman
300 Summit St., Galena 61036
Secretary: William G. Gillies
300 Summit St., Galena 61036
Members: 8—District No. 1

KANE COUNTY
President: John M. Abell
1870 W. Galena Blvd., Aurora 60506
Secretary: A. G. Baxter
34 N. Water St., Batavia 60510
Corresponding Secretary: Elsa Carlson
17 N. Sixth St., Geneva 60134
Members: 264—District No. 1

KANKAKEE COUNTY
President: James H. Ryan
1309 E. Court St., Kankakee 60901
Secretary: Herbert P. Swartz
450 Kennedy Dr., Kankakee 60901
Members: 93—District No. 11

KENDALL COUNTY
President: John P. Cullinan
Main St., Oswego 60543
Secretary: Joseph L. Daw
985 Lindenwood Dr., Montgomery 60538
Members: 9—District No. 11

KNOX COUNTY
President: E. A. Crowell
311 E. Main St., Galesburg 61401
Secretary: Walter J. Zich
St. Mary's Hospital, Galesburg 61401
Members: 73—District No. 4

LAKE COUNTY
President: Herman B. Lustigman
303 Waukegan Ave., Highwood 60040
Secretary: Ralph Elson
700 Deerfield, Deerfield 60015
Executive Secretary: Mrs. Julie P. Schulz
P.O. Box 148, Gurnee 60031
Members: 265—District No. 1

LA SALLE COUNTY
President: William E. Ehling
712 N. Bloomington, Streator 61364
Secretary: Allan L. Goslin
1005 N. Park St., Streator 61364
Members: 117—District No. 2

LAWRENCE COUNTY
President: Roger T. Kirkwood
Kensler Bldg., Lawrenceville 62439
Secretary: Gilbert Miller
Kensler Bldg., Lawrenceville 62439
Executive Secretary: Ruth E. Gariepy
Lawrence City Mem. Hospital, Lawrenceville 62439
Members: 11—District No. 8

LEE COUNTY
President: Donald Edwards
821 S. Peoria St., Dixon 61021
Secretary: George Silvest
114 E. Everett Ave., Dixon 61021
Members: 20—District No. 2

LIVINGSTON COUNTY
President: Andrew McGee
717 N. Main St., Pontiac 61764
Secretary: Dean G. Peterson
204 N. Locust St., Pontiac 61764
Members: 30—District No. 2

LOGAN COUNTY
President: Edward A. Ulrich
Forrest Hills, Lincoln 62656
Secretary: Glen E. Tomlinson
4 Lincoln Prof. Park, Lincoln 62656
Members: 29—District No. 5

MACON COUNTY
President: Hubert C. Magill
1170 E. Riverside, Decatur 62521
Secretary: Paul Reeder
2113 N. Edward, Decatur 62526
Executive Secretary: Mary J. Bretz
1800 E. Lake Shore Dr., Decatur 62521
Members: 149—District No. 7

MACOUPIN COUNTY
President: W. W. Lusk
224 E. Main St., Carlinville 62626
Secretary: J. J. Grandone
109 W. Pine, Gillespie 62033
Members: 27—District No. 6

MADISON COUNTY
President: H. A. Mittleman
304 St. Louis Ave., East Alton 62832
Secretary: Leo R. Green
1114 Milton Rd., Alton 62002
Members: 133—District No. 6

MARION COUNTY
President: Harold E. Snow
418 S. Popular St., Centralia 62801
Secretary: Walter Plassman
Box 552, Centralia 62801
Members: 35—District No. 7

MASON COUNTY
President: Dario Landazuri
125 N. Orange St., Havana 62644
Secretary: Henry W. Maxfield, Mason City 62664
Members: 14—District No. 5

MASSAC COUNTY
President: E. Yap
510 W. 10th St., Metropolis 62960
Secretary: Virgil O. Decker
105½ E. 5th St., Metropolis 62960
Members: 9—District No. 9

MCDONOUGH COUNTY
President: V. B. Adams
301 E. Jefferson St., Macomb 61455
Secretary: J. L. Symmonds
301 E. Jefferson St., Macomb 61455
Members: 20—District No. 4

McHenry County
President: Peter Griesbach
1110 N. Green St., McHenry 60050
Secretary: V. B. Petralia
210 Northwest Highway, Fox River 60021
Executive Secretary: Evelyn Rosulek
308 Kimball Ave., Woodstock 60098
Members: 57—District No. 1

McLean County
President: George W. France
429 N. Main St., Bloomington 61701
Secretary: Preston Houk
429 N. Main St., Bloomington 61701
Executive Secretary: David W. Meister
429 N. Main St., Bloomington 61701
Members: 87—District No. 5

Menard County
President: Robert Schafer
116 N. 5th St., Petersburg 62675
Secretary: H. K. Moulton
119 N. 7th St., Petersburg 62675
Members: 4—District No. 5

Mercer County
President: Wilbur A. Miller
109 N. College Ave., Aledo 61231
Secretary: James W. Hastings
209 S. College Ave., Aledo 61231
Members: 6—District No. 4

Monroe County
President: Otto Kremer
854 W. Bottom, Columbia 62236
Secretary: Edilberto F. Maglasang
911 Briegel, Columbia 62236
Members: 9—District No. 10

Montgomery County
President: Rudolf Sommer
515 N. Monroe St., Litchfield 62056
Secretary: Vincent J. Parlente
302 S. Main St., Hillsboro 62049
Members: 16—District No. 5

Morgan County
President: Joseph J. Kozma
1440 W. Walnut, Jacksonville 62650
Secretary: Robert H. Kooiker
801 Lincoln Ave., Jacksonville 62650
Members: 44—District No. 6

Moultrie County
President: H. E. Kendall, Sullivan 61951
Secretary: Dean McLaughlin, Sullivan 61951
Members: 7—District No. 7

Ogle County
President: Warren Duane Dodd
226 Blackhawk Dr., Byron 61010
Secretary: Roger Hofmeister
102 Kable Sq., Mt. Morris 61054
Members: 27—District No. 1

Peoria County
President: Charles G. Farnum
427 First Natl. Bank Bldg., Peoria 61602
Secretary: Paul R. Dirkse
427 First Nat'l. Bank Bldg., Peoria 61602
Executive Secretary: David W. Meister
427 First Nat'l. Bank Bldg., Peoria 61602
Members: 250—District No. 4

Perry County
President: George D. Mohr
206 N. Main, Pickneyville 62274
Secretary: James B. Stotlar
15 N. Walnut St., Pickneyville 62274
Members: 22—District No. 10

Piatt County
President: George Green
340 N. State St., Monticello 61856
Secretary: Joseph Allman
121 N. State St., Monticello 61856
Members: 8—District No. 7

Pike County
President: C. B. Lara
326 W. Washington, Pittsfield 62363
Secretary: Thomas C. Bunting
321 W. Washington, Pittsfield 62363
Members: 9—District No. 6

Pulaski County
President: James Conger, Mounds 62964
Secretary: Alphonso Robinson, Mounds 62964
Members: 2—District No. 10

Randolph County
President: V. S. Katty
307 E. Broadway, Steeleville 62288
Secretary: C. S. Schlageter
101 N. Market, Sparta 62286
Members: 18—District No. 10

Richland County
President: James Landis
426 Whittle, Olney 62450
Secretary: John Spangler
600 E. Main St., Olney 62450
Members: 25—District No. 8

Rock Island County
President: C. P. O'Neill
1740 Ninth Ave., Rock Island 61201
Secretary: B. H. Shevick
729 3rd Ave., Moline 61265
Members: 148—District No. 4

St. Clair County
President: William Knaus
4825 Main St., Belleville 62223
Secretary: Charles Frazer
4825 W. Main St., Belleville 62223
Executive Secretary: Joe Gasparich
4825 W. Main St., Belleville 62223
Members: 173—District No. 10

Saline-Pope-Hardin County
President: John R. Duffey, Roseclare 62982
Secretary: William R. Durham
203 N. Vine St., Harrisburg 62946
Members: 21—District No. 9

Sangamon County
President: Patrick McVary
1218 S. 7th St., Springfield 62703
Secretary: David B. Lewis
Memorial Hospital, Springfield 62701
Members: 215—District No. 5

Schuyler County
President: Rosemary Utter
513 W. Clinton, Rushville 62681
Secretary: Henry C. Zingher
Rushville Clinic, Rushville 62681
Members: 5—District No. 4

Shelby County
President: Otto G. Kauder, Findlay 62534
Secretary: Smith D. Taylor
520 Penns. Ave., Windsor 61957
Members: 9—District No. 7

Stephenson County
President: Thomas A. Haymond
222 W. Exchange, Freeport 61032
Secretary: F. C. Tucker
420 S. Harlem Ave., Freeport 61032
Members: 20—District No. 1

Tazewell County
President: Robert G. Rhoades
427 First Nat'l. Bank Bldg., Peoria 61602
Secretary: Erik Maran
427 First Nat'l Bank Bldg., Peoria 61602
Executive Secretary: David W. Meister
427 First Nat'l. Bank Bldg., Peoria 61602
Members: 44—District No. 5

Union County
President: William H. Whiting
Box 410, Anna 62906
Secretary: William H. Whiting
Box 410, Anna 62906
Members: 8—District No. 10

Vermilion County
President: E. M. Laury
605 N. Logan, Danville 61832
Secretary: L. W. Tanner
7 N. Virginia, Danville 61832
Members: 85—District No. 8

Wabash County
President: R. A. Richey, Grayville 62844
Secretary: C. L. Johns
114 W. Fifth, Mt. Carmel 62863
Members: 8—District No. 9

Warren County
President: Joseph Simmons, Kirkwood 61447
Secretary: Glen Chamberlin
219 E. Euclid, Monmouth 61462
Members: 12—District No. 4

Washington County
President: Charles W. Longwell
121 E. Elm St., Nashville 62263
Secretary: W. P. Lesko
111 N. Mill, Nashville 62263
Members: 4—District No. 10

Wayne County
President: D. A. Gershenson
308 E. Main, Fairfield 62837
Secretary: C. J. Jannings
101 E. Center St., Fairfield 62837
Members: 6—District No. 9

White County
President: P. D. Boren
507 W. Main St., Carmi 62821
Secretary: J. G. Harrell, Carmi 62821
Members: 7—District No. 9

Whiteside County
President: Edgar Picken
101 E. Miller Rd., Sterling 61081
Secretary: Saul Parks
1601 First Ave., Sterling 61080
Members: 43—District No. 2

Will- Grundy County
President: John H. Kendall
333 N. Madison, Joliet 60435
Secretary: Richard A. Tarizzo
2112 W. Jefferson #246, Joilet 60435
Executive Director: vacant
Members: 183—District No. 11

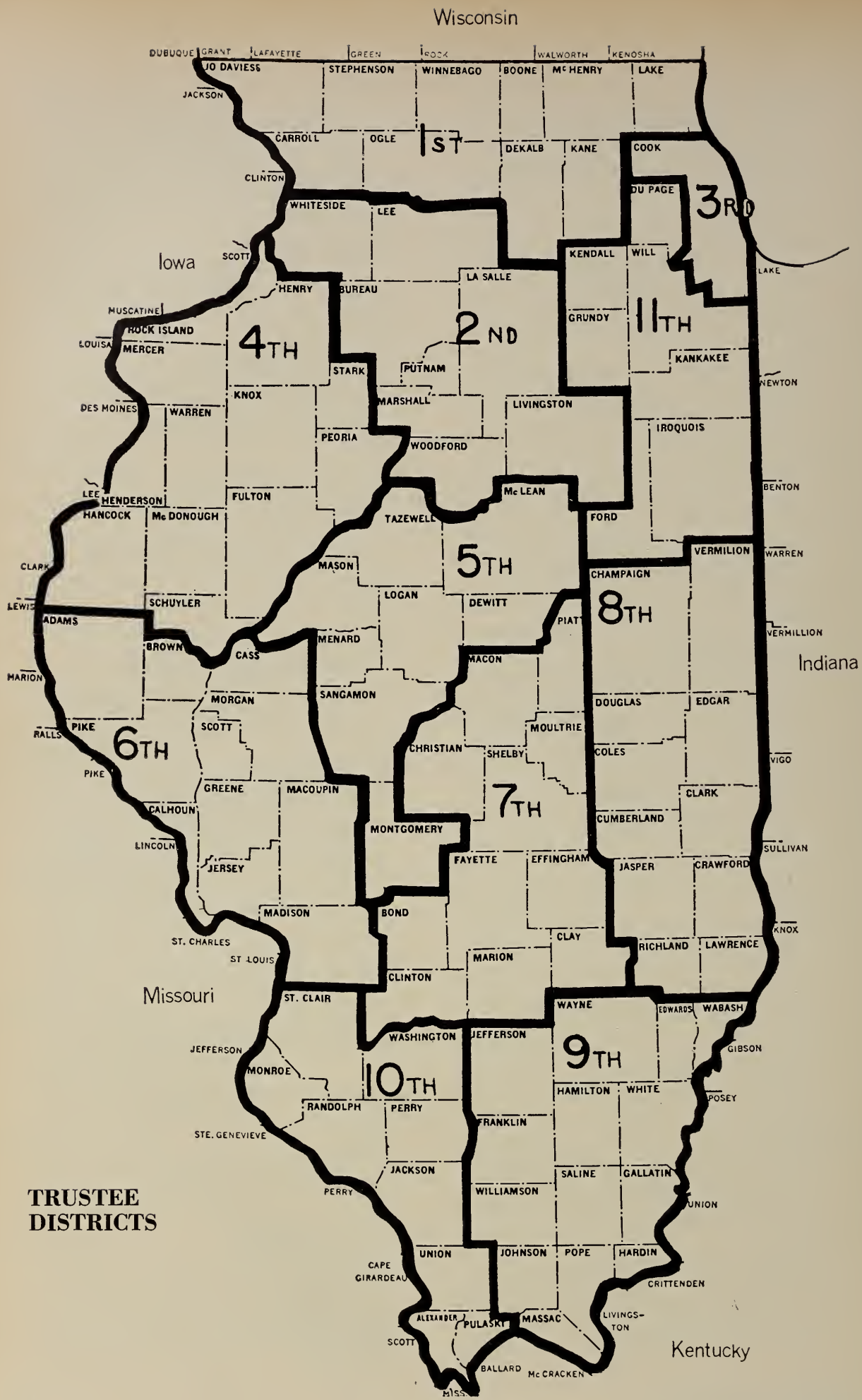
Williamson County
President: James Felts
517 Bainbridge Rd., Marion 62959
Secretary: Herbert V. Fine
110 N. Division, Carterville 62918
Members: 26—District No. 9

Winnebago County
President: Harold E. Zenisek
6670 E. State, Rockford 61108
Secretary: Robert A. Behmer
2500 N. Rockton Ave., Rockford 61103
Executive Administrator: Donald A. Westbrook
310 N. Wyman St., Rockford 61101
Members: 268—District No. 1

Woodford County
President: K. Vaicius
511 Oak St., Minonk 61760
Secretary: Victor Jay
601 N. Jefferson, Washburn 61570
Members: 10—District No. 2

No Organized County Society
Brown
Johnson
Marshall
Putnam
Scott

Joint County Societies
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Saline-Pope-Hardin
Will-Grundy


Wisconsin
DUBUQUE
GRANT
LAFAYETTE
GREEN
ROCK
WALWORTH
KENOSHA
JO DAVIESS
STEPHENSON
WINNEBAGO
BOONE
Mc HENRY
LAKE
JACKSON
CARROLL
OGLE
1ST
DEKALB
KANE
COOK
CLINTON
DU PAGE
3RD
WHITESIDE
LEE
Iowa
SCOTT
KENDALL
WILL
LAKE
HENRY
BUREAU
LA SALLE
MUSCATINE
GRUNDY
11TH
ROCK ISLAND
2ND
LOUISA
MERCER
4TH
KANKAKEE
STARK
PUTNAM
NEWTON
KNOX
DES MOINES
WARREN
MARSHALL
LIVINGSTON
IROQUOIS
PEORIA
WOODFORD
LEE
HENDERSON
FULTON
Mc LEAN
BENTON
HANCOCK
Mc DONOUGH
TAZEWELL
FORD
VERMILION
WARREN
CLARK
MASON
5TH
CHAMPAIGN
SCHUYLER
LOGAN
DEWITT
8TH
LEWIS
ADAMS
PIATT
VERMILLION
BROWN
CASS
MENARD
MACON
Indiana
MARION
MORGAN
SANGAMON
DOUGLAS
EDGAR
RALLS
PIKE
SCOTT
6TH
MOULTRIE
CHRISTIAN
SHELBY
COLES
VIGO
PIKE
GREENE
MACOUPIN
7TH
CLARK
CALHOUN
CUMBERLAND
MONTGOMERY
LINCOLN
SULLIVAN
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD
MADISON
BOND
CLAY
KNOX
ST. CHARLES
RICHLAND
LAWRENCE
ST LOUIS
MARION
CLINTON
Missouri
ST. CLAIR
WAYNE
EDWARDS
WABASH
WASHINGTON
JEFFERSON
9TH
GIBSON
JEFFERSON
MONROE
10TH
HAMILTON
WHITE
POSEY
RANDOLPH
PERRY
FRANKLIN
STE. GENEVIEVE
JACKSON
SALINE
GALLATIN
PERRY
WILLIAMSON
UNION
UNION
JOHNSON
POPE
HARDIN
CAPE GIRARDEAU
CRITTENDEN
ALEXANDER
PULASKI
MASSAC
LIVINGS-TON
SCOTT
Kentucky
BALLARD
Mc CRACKEN
Miss.
TRUSTEE DISTRICTS

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Kane, Lake, McHenry, Ogle, Stephenson, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1969
Benjamin F. Shirer, Batavia	1970
John W. Ovitz Jr., Sycamore	1971
E. J. McKinney, Rockford	1969

Grievance Committee	
Russell Zack, Rochelle, *Chairman*	1970
M. Mijanovich, Marengo	1971
A. K. Matthews, Rockford	1969
Walter J. Reedy, Waukegan	1969

Prepayment Plans & Organizations	
Kenneth L. Morris, Waukegan, *Chairman*	1969
Delbert O. Williams, Jr., Stockton	1971
Jerald A. Bowman, Rockford	1971
Rodney Nelson, Geneva	1969
Erwin A. Schilling, Rockford	1969
R. E. Whitsitt, Rockford	1969
John E. Madden, Freeport	1970

Second District

William A. McNichols, Jr., Dixon, *Trustee*
Counties of Bureau, LaSalle, Lee, Livingston, Marshall, Putnam, Whiteside, Woodford

Ethical Relations Committee	
K. Dexter Nelson, Princeton, *Chairman*	1971
Ralph Bailey, Ottawa	1969
Tim Sullivan, Sterling	1970

Grievance Committee	
K. M. Nelson, Princeton, *Chairman*	1969
Francis J. Brennan, Utica	1970
Edward Murphy, Dixon	1971
Philip Terry, Kewanee	1970

Prepayment Plans & Organizations	
M. D. Burnstine, Sterling, *Chairman*	1970
Wm. Ehling, Streator	1971
Joseph Phifer, Eureka	1969

Third District

William E. Adams, Chicago, *Trustee*
J. Ernest Breed, Chicago, *Trustee*
James B. Hartney, Oak Park, *Trustee*
Frank J. Jirka, Jr., River Forest, *Trustee*
William M. Lees, Lincolnwood, *Trustee*
Warren W. Young, Chicago, *Trustee*
No district committees are appointed.

Fourth District

Paul P. Youngberg, Moline, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

Ethical Relations Committee	Term Expires
John Bowman, Abingdon, *Chairman*	1970
Richard Icenogle, Roseville	1971
William D. Larsen, Annawan	1969

Grievance Committee	
F. A. Christensen, Peoria, *Chairman*	1969
Elliott Parker, Moline	1971
Russell Jensen, Monmouth	1970

Prepayment Plans & Organizations	
James C. Parsons, Geneseo, *Chairman*	1970
Donald Dexter, Macomb	1971
William O. McQuiston, Peoria	1969

Fifth District

Darrell H. Trumpe, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

Ethical Relations Committee	
Arthur Conklin, Bloomington, *Chairman*	1970
William W. Curtis, Springfield	1971
Rudolph A. Helden, Pekin	1969

Grievance Committee	
Clifford Draper, Hillsboro, *Chairman*	1969
A. J. Morris, Springfield	1970
James Borgerson, Mt. Pulaski	1971

Prepayment Plans & Organizations	
J. G. Meyer, Jr., Springfield, *Chairman*	1969
Robert B. Perry, Lincoln	1970
Robert Price, Bloomington	1971

Sixth District

Mather Pfeiffenberger, Alton, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Leo R. Greene, Alton, *Chairman*	1969
W. W. Bowers, Granite City	1970
Joseph J. Grandone, Gillespie	1971
Edward K. DuVivier, Alton	1971
Grievance Committee	
Robert R. Hartman, Jacksonville, *Chairman*	1969
Bruno DeSulis, Beardstown	1971
Robert C. Murphy, Quincy	1970
Richard Cooper, Quincy	1971
Prepayment Plans & Organizations	
Paul A. Dailey, Carrollton, Chairman	1971
E. C. Bone, Jacksonville	1970
Jude A. Caselton, Carrollton	1969
Frank B. Norbury, Jacksonville	1969
Meyer Shulman, Pittsfield	1971

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt and Shelby

Ethical Relations Committee	Term Expires
Max Hirschfelder, Centralia, *Chairman*	1971
E. H. Rames, Vandalia	1969
Carl L. Sandburg, Decatur	1970
Grievance Committee	
Karl D. Venters, Centralia, *Chairman*	1970
Boyd McCracken, Greenville	1971
William Sargent, Effingham	1969
Prepayment Plans & Organizations	
Clarence Glenn, Decatur, *Chairman*	1969
Richard Larson, Shelbyville	1971
Stanley W. Moore, Vandalia	1970

Eighth District

William H. Schowengerdt, Champaign, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	
Mack W. Hollowell, Charleston, *Chairman*	1971
James H. Pass, Olney	1969
Alan M. Taylor, Danville	1970
Grievance Committee	
A. R. Brandenberger, Danville, *Chairman*	1971
Eugene Johnson, Casey	1969
Gordon Sprague, Paris	1970
Prepayment Plans & Organizations	
James W. Landis, Olney, *Chairman*	1971
E. A. Kendall, Mattoon	1970
George T. Mitchell, Marshall	1969

Ninth District

Charles K. Wells, Mt. Vernon, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Johnson, Massac, Pope, Saline, Wabash, Wayne, White, Williamson

Ethical Relations Committee	
Donald Mitchell, McLeansboro, *Chairman*	1970
Philip Boren, Carmi	1971
John P. Pope, Benton	1969
Grievance Committee	
C. J. Jannings, III, Fairfield, *Chairman*	1970
Herbert Fine, Carterville	1969
John Duffey, Rosiclare	1971
Prepayment Plans & Organizations	
Denton Farrell, Eldorado, *Chairman*	1971
H. L. Lewis, Benton	1970
A. Watson Miller, Herrin	1969

Tenth District

Willard C. Scrivner, East St. Louis, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, Washington

Ethical Relations Committee	
William Borgsmiller, Murphysboro, *Chairman*	1969
Harold McCann, East St. Louis	1971
A. L. Robinson, Mounds	1970
Grievance Committee	
William H. Walton, Belleville, *Chairman*	1969
William H. Whiting, Anna	1971
George Cutridge, DuQuoin	1970
Prepayment Plans & Organizations	
R. W. Jost, Waterloo, *Chairman*	1969
R. E. Schettler, Red Bud	1971
Joseph A. Petrazio, Murphysboro	1970

Eleventh District
Joseph R. O'Donnell, Glen Ellyn, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois,
Kankakee, Kendall, Will

Ethical Relations Committee
Donald A. Meier, Kankakee, *Chairman* 1969
Lawrence D. Lee, Manhattan 1970
John Bowden, Joilet 1971

Grievance Committee
William C. Perkins, West Chicago,
Chairman 1970
Samuel J. Goldhaber, Joilet 1969
Victor Smith, Newark 1971

Prepayment Plans & Organizations
Chas. Allison, Kankakee, *Chairman* 1969
James E. Dailey, Watseka 1969
James Lambert, Joilet 1970
Julius Schweitzer, Hinsdale 1971

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 18, 1966
(To serve from Jan. 1, 1967 to Dec. 31, 1968)
MAURICE M. HOELTGEN
1836 W. 87th St., Chicago
LEO P. A. SWEENEY
2658 W. 95th St., Chicago
H. CLOSE HESSELTINE
5708 S. Dorchester Ave., Chicago
WILLIAM K. FORD
303 N. Main St., Rockford
JACOB E. REISCH
1129 S. 2nd. St., Springfield

Elected May 24, 1967
(To serve from Jan. 1, 1968 to Dec. 31, 1969)
H. KENNETH SCATLIFF
1415 Greenleaf Ave., Chicago
WALTER C. BORNEMEIER
4665 Peterson Ave., Chicago
FRANK H. FOWLER
6356 Diversey Ave., Chicago
ARTHUR F. GOODYEAR
142 E. Prairie Ave., Decatur
HARLAN ENGLISH
909 N. Logan Ave., Danville
EDWARD W. CANNADY
4601 State St., East St. Louis

Elected May 21, 1968
(To serve from Jan. 1, 1969 to Dec. 31, 1970)
Maurice M. Hoeltgen
Leo P. A. Sweeney
H. Close Hesseltine
William K. Ford
Jacob E. Reisch
Honorary Delegates
Edwin S. Hamilton,
151 N. Schuyler St., Kankakee
Burtis E. Montgomery,
37 S. Main St., Harrisburg
George F. Lull,
2440 Lakeview, Chicago

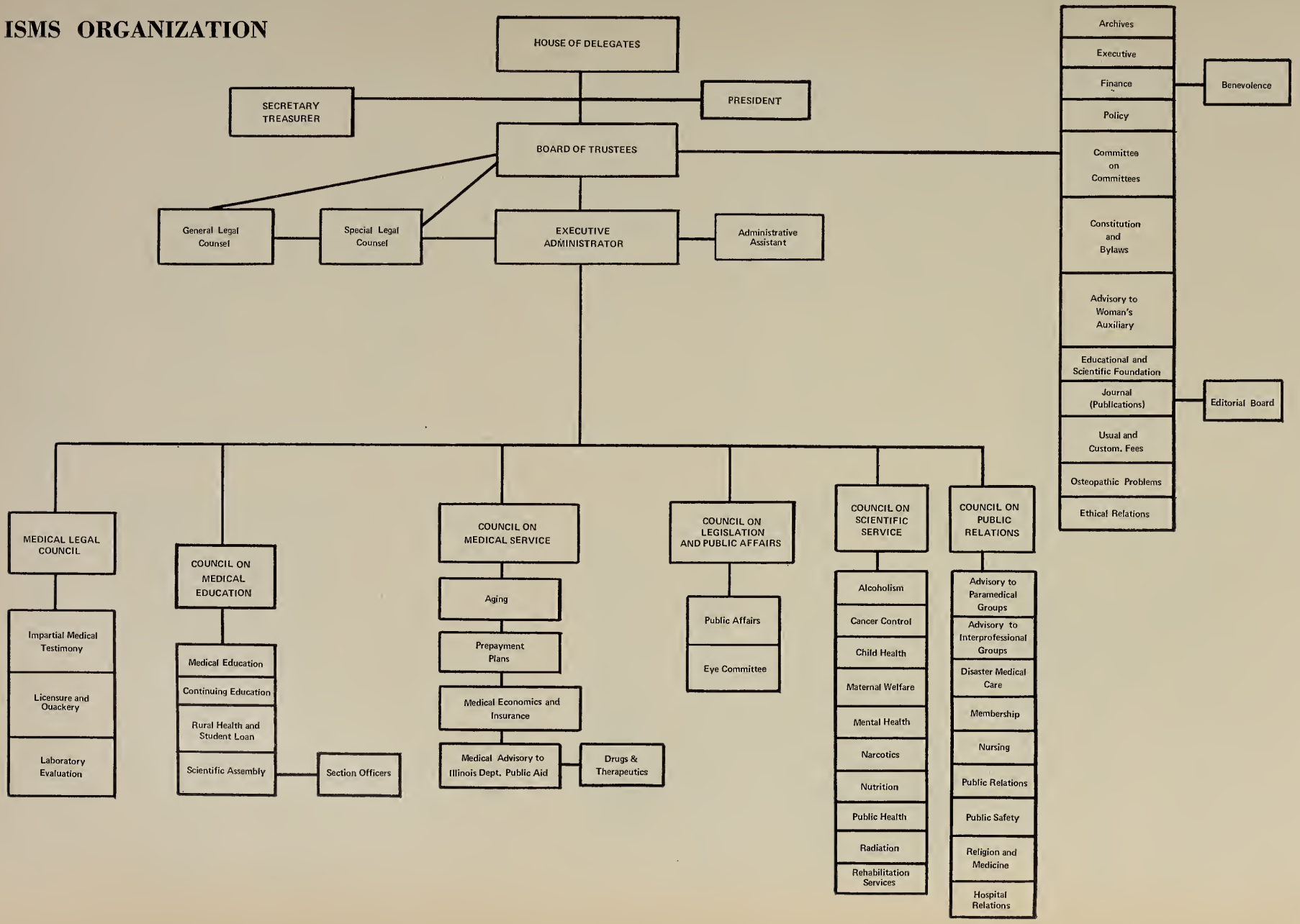
ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 18, 1966
(To serve from Jan. 1, 1967 to Dec. 31, 1968)
Theodore R. Van Dellen, 435 N. Michigan Ave., Chicago
Allison L. Burdick, Sr., 5906 W. North Ave., Chicago
Arkell M. Vaughn, 9012 S. Leavitt St., Chicago
Paul A. Dailey, 620 N. Main St., Carrollton
Fred C. Endres, 229 E. Glen Ave., Peoria

Elected May 24, 1967
(To serve from Jan. 1, 1968 to Dec. 31, 1969)
Harold A. Sofield, 715 Lake St., Oak Park
George C. Turner, 6627 Ponchartrain Ave., Chicago
Edward A. Piszczek, 6410 N. Leona Ave., Chicago
Newton DuPuy, 1842 Grove Ave., Quincy
Joseph R. Mallory, Link Clinic, Mattoon
Carl E. Clark, Sycamore

Elected May 21, 1968
(To serve from Jan. 1, 1969 to Dec. 31, 1970)
Theodore R. Van Dellen
Allison L. Burdick, Sr.
Arkell M. Vaughn
Paul A. Dailey
Jack Gibbs, Coleman Clinic, Canton

ISMS ORGANIZATION



Councils of the Illinois State Medical Society

Committees of the Illinois State Medical Society are appointed by the Board of Trustees and are assigned to one of six councils which report directly to the Board. Councils are composed, for the most part, of committee chairmen.

COUNCIL ON LEGISLATION AND PUBLIC AFFAIRS

V. P. Siegel, *Chairman,* 4601 State St., East St. Louis 62205
Richard Allyn, 709 Myers Building, Springfield 62701
Alfred J. Faber, 2110 Swainwood Dr., Glenview 60025
Theodore Grevas, (Public Affairs) 1800 Third Ave., Rock Island 61201
Frank J. Kresca, (Eye) 208 W. Green, Champaign 61822
Eugene J. Scherba, 13826 Lincoln Ave., Dolton 60419
Thomas P. deGraffenried, 1208 Sunnymeade, DeKalb 60115

CONSULTANTS:

H. Close Hesseltine, 5807 S. Dorchester Avenue, Chicago 60637
Harold A. Sofield, 715 Lake St., Oak Park 60301
J. Ernest Breed, 55 E. Washington, Chicago 60602
William A. Lees, 6518 N. Nokomis, Lincolnwood 60646

AUXILIARY:

Mrs. Alan Taylor, 1607 N. Vermilion, Danville 61832

STAFF: Dan Morgan

Responsibilities and Purposes

The Council on Legislation and Public Affairs shall:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois,
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois,
3. Cooperate with the AMA in similar programs and,
4. Shall develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

MEDICAL-LEGAL COUNCIL

Noel G. Shaw, *Chairman,* 2901 Central St., Evanston 60201
Clinton L. Compere, (Impartial Medical Testimony) 737 N. Michigan Ave., Chicago 60611
William G. McCarthy, (Medical Practice and Quackery) 13826 Lincoln, Dolton 60419
George Alvary, 1110 N. Green, McHenry 60050
Andrew John Toman, 6738 W. Cermak Rd., Berwyn 60609
Grover L. Seitzinger, (Laboratory Evaluation) 812 N. Logan Ave., Danville 61832

STAFF: Mel Sloan

Responsibilities and Purposes

Special attention shall be given to liaison with the Bar Association. The responsibilities formerly assigned to the Medical Legal Committee shall be provided by this council as follows: to educate the members of the profession in medico-legal affairs and cooperate with the AMA in its program.

The same shall pertain to the work of the former Committee on Medical Testimony, and this council shall have the authority to examine any member of the ISMS who is either suspected of, or has been accused of giving improper testimony in any court proceedings. It shall (if deemed necessary) procure and examine transcripts of court testimony to determine whether or not fraudulent testimony has been given and report its findings to the Board of Trustees. When irregularities are found, the Board may submit the findings to the Ethical Relations Committee of the county medical society.

A committee may be appointed to act with members of a similar committee of the Illinois Bar Association in matters involving both professions.

COUNCIL ON MEDICAL EDUCATION

Jack Gibbs, *Chairman* (Rural Health & Student Loan), 24 Main St., Canton 61520
Herschel L. Browns, (Continuing Education), 4600 N. Ravenswood Avenue, Chicago 60640
Robert T. Fox, (Scientific Assembly), 2136 Robin Crest Lane, Glenview 60025
Morgan M. Meyer, (Medical Education), 573 South Lombard, Lombard 60148
J. Robert Thompson, (Director of Exhibits), 1129 North Elmwood Avenue, Oak Park 60302
CONSULTANT:
Paul W. Sunderland, 214 North Sangamon Street, Gibson City 60936
STAFF: Perry L. Smithers

Responsibilities and Purposes

The Council on Medical Education shall (1) study and evaluate all phases of medical education including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians; (2) study and evaluate education relating to the health professions and services important to medicine, including the development of programs approved by the House of Delegates, for the provision of a continuing supply of well-qualified personnel in these fields; (3) carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician; (4) study, evaluate and criticize the post-graduate programs of ISMS and other organizations; (5) be available to advise and cooperate with the Department of Registration and Education of the State of Illinois; and (6) organize, coordinate and administer the scientific sessions of the ISMS subject to the regulations outlined in the Bylaws, especially those in Chapter II, Annual Convention, Section 3, Scientific Meetings.

COUNCIL ON MEDICAL SERVICE

Fred Z. White, *Chairman,* (Medical Economics & Insurance) 723 N. 2nd St., Chillicothe 61523
Preston S. Houk (Prepayment Plans), 207 Parkview Dr., Bloomington 61701
T. T. Tourlentes (Aging), Galesburg Research Hosp., Galesburg 61401
Fred A. Tworoger (Adv. to IDPA), 4753 Broadway, Chicago 60640
STAFF: James Slawny

Responsibilities and Purposes

1) Coordinate committee activities, avoid duplication in over-lapping of projects, close gaps in medical service programming and serve as a catalyst in activating new committee programs,
2) Initiate, explore and bring to the attention of the Board of Trustees suggested new policies and philosophies relating to medical service in Illinois,
3) Serve as an advisory body to allow for the interchange of ideas between various committees of the Council,
4) Consult with Council members as chairmen of committees with similar aims and objectives,
5) Advise the staff in socio-economic issues and further the health and welfare of the public by seeking continuous improvement of medical services in Illinois,
6) Establish liaison with other Councils of organized medicine, including those of the AMA, and
7) Provide a channel of communication between the Illinois State Medical Society and the federal health agencies, the health insurance industry, the Blue Cross-Blue Shield Plans, and similar organizations in matters of mutual concern.

COUNCIL ON PUBLIC RELATIONS

Thomas R. Harwood, *Chairman,* (Adv. to Paramedical Groups), 4902 Tollview Rd., Rolling Meadows 60008
Max Klinghoffer (Disaster Medical Care), 127 E. Vallette St., Elmhurst 60126
Julian W. Buser (Hospital Relations), 4601 State St., East St. Louis 62205
Matthew B. Eisele (Public Relations), 4601 State St., East St. Louis 62205
Robert S. Mendelsohn (Religion and Medicine), 1100 Hull Terrace, Evanston 60202
Henry A. Holle (Membership), 160 N. LaSalle St., Chicago 60601
James D. Majerakis (Adv. to Interprofessional Groups), 30 N. Michigan Ave., Chicago 60602
W. I. Taylor (Nursing), 28 N. Main St., Canton 61520
Edwin A. Lee (Public Safety), 501 S. 13th St., Springfield 62703
STAFF: James R. Slawny

Responsibilities and Purposes

The Council on Public Relations shall plan and execute programs designed to enhance the relationship between the public and the medical profession.

COUNCIL ON SCIENTIFIC SERVICES

Joseph H. Skom, *Chairman,* (Narcotics) 707 N. Fairbanks Ct., Chicago 60611
John R. Adams, (Mental Health) 707 N. Fairbanks Ct., Chicago 60611
Henry B. Betts, (Rehabilitation Services), 401 E. Ohio, Chicago 60611
Howard D. Burkhead, (Radiation), 130 Dempster St., Evanston 60201
Paul A. Dailey (Nutrition), 620 N. Main Street, Carrollton 62016
Abraham Gelperin, (Alcoholism), DMP-Room 554, 1853 W. Polk, Chicago 60612
Robert R. Hartman, (Maternal Welfare), 1515 Walnut, Jacksonville 62650
Ralph H. Kunstadter, (Child Health), 664 N. Michigan Avenue, Chicago 60611
Edward A. Piszczek, (Public Health), 6410 N. Leona, Chicago 60646
John V. Standard, (Cancer Control), 701 N. Walnut, Springfield 62702
STAFF: Perry L. Smithers

Responsibilities and Purposes

The Council on Scientific Services shall (1) encourage and assist in the development of community programs designed to maintain, protect and improve the health of residents of the State of Illinois; (2) cooperate with the Illinois Department of Health in the control and prevention of contagious diseases; (3) formulate and participate in programs designed to decrease occupational, environmental, and physical hazards; (4) recommend and promulgate standards for ancillary medical services; (5) participate and advise in programs designed to reduce morbidity and mortality in diseases peculiar to any segment of the people of Illinois; (6) work for the establishment of measures for the control of hazardous drugs and agents; and (7) develop and support legislative measures to accomplish these aims.

COMMITTEES

The following committees have been appointed for the year, 1968-69. Each committee is assigned to a council for reporting purposes, except those that are composed entirely of trustees, or for reasons of efficiency and control, report directly to the Board of Trustees.

COMMITTEE ON AGING
(Council on Medical Service)

Thomas T. Tourlentes, *Chairman*
Galesburg Research Hospital, Galesburg 61401

Bertram B. Moss
5360 N. Lincoln Ave., Chicago 60625

Marshall Falk
226 Kilpatrick, Wilmette 60091

M. H. Powell
306 W. Main St., Carbondale 62901

Ralph A. Rittenhouse
P.O. Box 248, Winfield 60190

Clyde Rulison
Roberts 60962

AUXILIARY REPRESENTATION:

Mrs. Herbert P. Swartz
575 S. Wall St., Kankakee 60901
STAFF: Gary Kennon

Responsibilities and Purposes

The functions of the Committee on Aging encompass the broad field of aging with special consideration for the types of medical services and patterns of care available to the aging and the economics involved, promotion of positive health and meaningful living through sound living habits, periodic health supervision, and full use of human potentials, regardless of age. The committee cooperates with the American Medical Association's Committee on Aging and other appropriate agencies.

Included among the committee's activities are the study and support of expansion of additional home care programs in Illinois; relationships with nursing homes, home nursing, homemaker programs, and other programs involving services oriented toward the aging; emphasizing preretirement planning; discouraging the mandatory retirement age and arbitrary age limits for employment whether the individual wants to continue working or not; and liaison with other agencies having a similar interest.

COMMITTEE ON ALCOHOLISM
(Council on Scientific Services)

Abraham Gelperin, *Chairman,* Room 554, D.M.P.
1853 W. Polk St., Chicago, 60612
Charles L. Anderson
120 N. Oak St., Hinsdale, 60521
Richard S. Cook
230 N. Michigan Ave., Chicago 60601
David J. Stinson
2026 Jonquil Place, Rockford, 61107
John C. Troxel
425 N. Michigan Ave., Chicago, 60611
Frank J. Walsh
6445 W. North Ave., Oak Park, 60302
William H. Wehrmacher
670 N. Michigan Ave., Chicago, 60611
STAFF: Perry L. Smithers

Responsibilities and Purposes

The Committee on Alcoholism serves as a resource on alcoholism for ISMS and evaluates information and makes recommendations to the Board of Trustees for the position ISMS should take on issues in this area. It cooperates with institutions, industry, government and health agencies in disseminating information on the causes, prevention, diagnosis, and treatment of alcoholism to the medical profession and the public.

ARCHIVES COMMITTEE
(Board of Trustees)

Leo Zimmerman, *Chairman*
55 E. Washington St., Chicago 60602
Everett P. Coleman
24 N. Main, Canton 61520
Emmet F. Pearson
701 N. Walnut St., Springfield 62702
H. Kenneth Scatliff
1415 Greenleaf Ave., Chicago 60625
STAFF: Frances C. Zimmer

Responsibilities and Purposes

Assist in the collection and evaluation of medical items and records of historical interest to the society and the public; cooperate with other associations and agencies to preserve and display such material; supervise the preparation of any written records of the society or any of its activities; and inform the Board of Trustees of those special anniversaries which should be commemorated and shall supervise the observance of these occasions.

SUB-COMMITTEE ON BENEVOLENCE
(See Finance Committee)

COMMITTEE ON CANCER CONTROL
(Council on Scientific Services)

John V. Standard, *Chairman*
701 N. Walnut, Springfield, 62702
Robert E. Field
13000 S. Maple, Blue Island, 60406
Russell M. Jensen
319 N. Main St., Monmouth, 61462
Roland A. Kowal
505 S. Oak Park Ave., Oak Park, 60302
Rudolph G. Mrazek
3237 S. Oak Park Ave., Berwyn, 60403
Thomas Sellett
101 E. Miller Rd., Sterling, 61081
Caesar Sweitzer
251 E. Chicago Ave., Chicago, 60611
AUXILIARY REPRESENTATION:
Mrs. Richard E. Icenogle
Box 188, Roseville, 61473

CONSULTANTS:
J. Ernest Breed
55 E. Washington St., Chicago 60602
Caesar Portes
25 E. Washington, Chicago, 60602
STAFF: Perry L. Smithers

Responsibilities and Purposes

This committee shall serve as a source of information on cancer matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees on the position the ISMS should take in this area of scientific endeavor. It shall cooperate with institutions and voluntary health agencies in disseminating information on cancer subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE ON CHILD HEALTH
(Council on Scientific Services)

Ralph H. Kunstadter, *Chairman*
664 N. Michigan Ave., Chicago 60611
Irving Abrams
228 N. LaSalle St., Chicago 60601
William J. Ball
143 S. Lincoln, Aurora 60505
Marvin E. Cooper
6450 N. California Ave., Chicago 60645
Eugene F. Diamond
11055 S. St. Louis, Chicago 60655
Richard E. Dukes
602 W. University, Urbana 61801
W. W. Fullerton
101 N. Market St., Sparta 62286
Edmond R. Hess
1737 W. Howard St., Chicago 60626
Howard R. Hone
151 Herrick Road, Riverside 60546
Edward Jung
13826 Lincoln Ave., Dolton 60419
Harvey Kravitz
6223 Dempster St., Morton Grove 60053
Edward F. Lis
840 S. Wood St., Chicago 60612
Fred Long
2116 N. Sheridan Rd., Peoria 61604
J. Keller Mack
922 S. 4th St., Springfield 62702
Franklin A. Munsey
1429 Myott Ave., Rockford 61101
Kenneth S. Nolan
172 Schiller, Elmhurst 60126
T. A. Palus
101 Orchard Terrace, Lombard 60148
Ira M. Rosenthal
700 S. Wood St., Chicago 60612
Norman T. Welford
656-58th St., Hinsdale 60521
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall serve as a source of information on matters pertaining to child health. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area and cooperate with institutions and voluntary health agencies in disseminating information pertinent to general child health. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public. It shall conduct educational programs for public enlightenment for the encouragement and the establishment of school health councils; it shall strive for increased services for exceptional children. It shall conduct in cooperation with the Maternal Welfare Committee research on neonatal mortality through the state; and shall seek the formulation and adoption of uniform school health records.

COMMITTEE ON COMMITTEES
(Board of Trustees)

Darrell H. Trumpe, *Chairman*
St. John's Sanatorium, Springfield 62707
James B. Hartney
410 Lake St., Oak Park 60302
Charles K. Wells
117 N. 10th St., Mt. Vernon 62824
Warren W. Young
10816 Parnell Ave., Chicago 60628
STAFF: Frances C. Zimmer

Responsibilities and Purposes

The Committee on Committees shall review annually the purpose, activity and structure of all committees, and shall recommend such changes in existing committees as appear to be required for the efficient conduct of the business of the Society.

The activities of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS
(Board of Trustees)

Andrew J. Brislen, *Chairman*
6060 S. Drexel Blvd., Chicago 60637
David S. Fox
826 E. 61st St., Chicago 60637
Wayne N. Leimbach
370 L.R.A. Dr., Aurora 60506
Edward A. Razim
3340 S. Oak Park Ave., Berwyn 60402
Carl Weissmann
1508-7th St., Moline 61265
STAFF: Frances C. Zimmer

Responsibilities and Purposes

The Committee on Constitution and Bylaws shall

a) Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws.
b) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws, and
c) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

COMMITTEE ON CONTINUING EDUCATION
(Council on Medical Education)

Herschel L. Browns, *Chairman*
4600 N. Ravenswood, Chicago 60640
W. W. Bowers
1820 Delmar, Granite City 62040
T. Howard Clarke
251 E. Chicago Ave., Chicago 60611
Robert Craig
2111 N. Edward St., Decatur 62526
Lawrence C. Day
121 W. Church St., Libertyville 60048
Robert J. Freeark
1825 W. Harrison St., Chicago 60612
Richard F. Herndon
326 N. 7th St., Springfield 62701
Louis N. Katz
2900 S. Ellis Ave., Chicago 60616
Louis R. Limarzi
910 N. East Ave., Oak Park 60302
James M. Schless
3249 S. Oak Park Ave., Berwyn 60402
Gordon S. Sprague
502 Shaw Ave., Paris 61944
CONSULTANT:
William E. Adams
55 E. Erie St., Chicago 60611
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall provide a program of continuing education for the practicing physicians of Illinois. This shall include courses in specific medical subjects as requested by component societies as well as speakers on scientific subjects. The committee shall solicit individuals or teams from the medical schools of Illinois, the hospitals and research centers and the body of practitioners to present this program of continuing education. It shall study more effective means of presenting educational material throughout the state. It shall provide additional services to component societies as are deemed necessary to the conduct of an effective program.

COMMITTEE ON DISASTER MEDICAL CARE
(Council on Public Relations)

Max Klinghoffer, *Chairman*
127 E. Vallette St., Elmhurst 60126
Jack R. Baldwin
1315 S. 6th St., Springfield 62703
William A. Hark
30 N. Michigan, Chicago 60602
Harold C. Lueth
636 Church St., Evanston 60201
Carl Steinhoff
8909 Kilpatrick Ave., Skokie 60076
Charles F. Sutton
505 State Office Bldg., Springfield 62706
STAFF: Gary Kennon

Responsibilities and Purposes

The committee shall be responsible for assisting in the education of the profession and the public on the development and implementation of programs to provide medical care in the event of disaster; be responsible for directing the society's efforts toward preparedness in the event of natural or man-made catastrophes; cooperate with civil defense agencies, public health departments, hospitals, management and labor organizations, paramedical groups and other agencies to establish unity and coordination, and serve in an advisory capacity to county medical societies in medical self-help training programs and hospital disaster planning.

SUB-COMMITTEE ON DRUGS AND THERAPEUTICS
(See Medical Advisory Committee to The Illinois Department of Public Aid)

EDITORIAL BOARD
(See Journal Committee)

EDUCATIONAL & SCIENTIFIC FOUNDATION
(Board of Trustees)

Newton DuPuy, Chairman
1842 N. Grove, Quincy 62301
Frank J. Jirka, Jr.
1507 N. Keystone Ave., River Forest 60305
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Perry Smithers

Responsibilities and Purposes

The foundation was founded to provide an administrative agency to foster the advancement of medical science through (1) the initiation of scientific and medical research activities, (2) the collection, evaluation and dissemination of the results of research activities to the public and (3) the implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge. The charter of the foundation calls for a board of directors consisting of the following officers of the Illinois State Medical Society: Immediate Past President (as chairman), Chairman of the Board of Trustees, President, and Secretary-Treasurer.

SUB-COMMITTEE ON ENVIRONMENTAL HEALTH
(See Committee on Public Health)

ETHICAL RELATIONS COMMITTEE
(Board of Trustees)

Willard C. Scrivner, *Chairman*
4601 State St., East St. Louis 62205
William A. McNichols, Jr.
101 W. First St., Dixon 61021
J. Ernest Breed
55 E. Washington, Chicago 60602
Newton DuPuy
1842 Grove Ave., Quincy 62301
STAFF: Roger N. White

Responsibilities and Purposes

The duties of this committee are outlined in details in the Bylaws under the chapter on "Discipline."

Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

It shall serve as an appellate body to review cases involving these matters referred by component medical societies, and shall consider matters of law (ethics) and procedure.

Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. Appeals must be accompanied by pertinent data and transcripts indicating the basis for the appeal. Failure to provide such data shall be grounds for a verdict of default against the plaintiff. The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Verdict. On conclusion of the hearing, the Ethical Relations Committee of the Board of Trustees shall meet in executive session to consider its decision, and shall report in writing to the Board at its next meeting for approval or rejection.

Notification of Parties. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board.

A. *Right of Appeal to the American Medical Association.* In case of findings against the accused, and in support of the action taken by the component society, the secretary of the state society shall notify the accused within ten days by certified mail of his right to appeal to the Judicial Council of the American Medical Association.

B. *Error.* In the event of a decision by the Board of Trustees of improper law (ethics) and/or procedure by the trial body of the component society, the case shall be remanded with recommendations to the component society for reconsideration.

The Committee shall be authorized by the Board of Trustees to:

1) Investigate
   (a) Controversies arising under this Constitution and Bylaws and under the principles of medical ethics, to which the Society is a party, and
   (b) Controversies between two or more county societies and their members.
2) Investigate all questions of medical ethics and the interpretation of the Constitution, Bylaws and Policies of the Society.
3) Investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public.
4) To receive appeals filed by applicants who alleged that they have been denied membership in a component society because of race, creed, color, or ethnic origin, to determine the facts of the case and to report the findings to the Board of Trustees.

EXECUTIVE COMMITTEE
(Board of Trustees)

Frank J. Jirka, *Chairman*
1507 Keystone Ave., River Forest 60305
Philip G. Thomsen, President
13826 Lincoln Ave., Dolton 60419
Edward W. Cannady, Pres.-elect
4601 State St., E. St. Louis 62205
William E. Lees, Finance
6518 N. Nokomis, Ave., Lincolnwood 60646
Newton DuPuy, Past Pres.
1842 Grove Ave., Quincy 62301
Jacob E. Reisch, Secy.-Treas.
1129 S. 2nd St., Springfield 62704
William E. Adams, Policy
55 E. Erie St., Chicago 60611
LEGAL COUNSEL:
John W. Neal
Frank M. Pfeifer
STAFF: Roger N. White
Frances C. Zimmer

Responsibilities and Purposes

The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer and the trustee-at-large.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

EYE COMMITTEE
(Council on Legislation & Public Affairs)

Frank J. Kresca, *Chairman*
208 W. Green, Champaign 61820
James R. Fitzgerald
6429 North Ave., Oak Park 60302
Edward C. Albers
Christie Clinic, 104 W. Clark St., Champaign 61820
Charles L. Pannabecker
331 Fulton, Peoria 61602
Lawrence J. Lawson
636 Church St., Evanston 60201
Wilbur W. Baumgartner
118 N. Chestnut St., Kewanee 61443
David V. Brown
122 S. Michigan Ave., Chicago 60604
Max Hirschfelder
408-2nd St., Centralia 62801
David Shock
700 N. Michigan Ave., Chicago 60611
Manuel L. Stillerman
111 N. Wabash Ave., Chicago 60602
M. Byron Weisbaum
520 E. Allen, Springfield 62703
CONSULTANT:
Maurice M. Hoeltgen
1836 W. 87th St., Chicago 60620
STAFF: Mel Sloan

Responsibilities and Purposes

The function of the Eye Committee is to concern itself with state legislation regarding ophthalmic matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Eye Committee also meets with the Illinois State Joint Council of Ophthalmology to study problems and formulate policy on the medical and social economic aspects of ophthalmology.

FINANCE COMMITTEE
(Board of Trustees)

William M. Lees, *Chairman*
6518 N. Nokomis Ave., Lincolnwood 60646
Mather Pfeiffenberger
State & Wall Sts., Alton 62002
William H. Schowengerdt
301 E. University Ave., Champaign 61820
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
LEGAL COUNSEL:
John W. Neal
Frank M. Pfeifer
CONSULTANT:
Carl E. Clark
225 Edward St., Sycamore 60178
STAFF: Roger N. White
Roland I. King

Responsibilities and Purposes

The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

COMMITTEE ON BENEVOLENCE
(Subcommittee of the Finance Committee)

Keith H. Frankhauser, *Chairman*
Avon 61415
Allison L. Burdick, Sr.
5906 W. North Ave., Chicago 60639
Leo P. A. Sweeney
2658 W. 95th St., Evergreen Park 60642
AUXILIARY REPRESENTATION:
Mrs. Michael G. Maitino
601 N. Taylor Ave., Oak Park 60302
STAFF: Frances C. Zimmer

Responsibilities and Purposes

The committee shall examine applications to the society for assistance to determine eligibility for benefits; keep the names of the beneficiaries confidential and known only to the committee, and recommend to the Finance Committee of the Board of Trustees the allotment of each recipient. It shall operate as a sub-committee of the Finance Committee.

If funds available become inadequate to meet disbursements, the Finance Committee of the Board of Trustees shall be requested to appropriate sufficient funds to support the program until the next budget appropriation.

SUB-COMMITTEE ON HEALTH CAREERS COUNCIL OF ILLINOIS
(See Advisory Committee to Paramedical Groups)

COMMITTEE ON HOSPITAL RELATIONS
(Council on Public Relations)

J. W. Buser, *Chairman*
4601 State St., East St. Louis 62205
John A. Bowman
300 N. Main St., Abingdon 61410
Caesar Portes
25 E. Washington St., Chicago 60602
Kenneth John Smith
2320 High St., Blue Island 60406
CONSULTANT:
Harlan English
909 N. Logan Ave., Danville 61832
STAFF: James Slawny

Responsibilities and Purposes

Among the functions of the committee are the consideration of all problems bearing on the relationship between physicians and hospitals except those pertaining to medical training. A prime objective of the committee is to encourage hospital staffs to become actively interested in the economics of hospital operation and hospital services. In areas of health insurance, nursing and items requiring *legislative action,* the committee should coordinate its activities with the respective committees of the society to avoid duplication of effort.

The committee will continue to work toward solving mutual problems pertaining to hospital utilization; medical, nursing and administrative care of patients; hospital costs; accreditation of nonaccredited hospitals; and to improve physician-hospital relationships in the interest of patient care.

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY
(Medical-Legal Council)

Clinton L. Compere, *Chairman*
737 N. Michigan, Chicago 60611
R. Gregory Green
1355 Charles St., Rockford 61108
Jerome J. McCullough
110 N. High St., Belleville 62202
Maurice D. Murfin
250 N. Water St., Decatur 62523
CONSULTANTS:
Samuel A. Levinson
3730 Lake Shore Dr., Chicago 60613
Vincent C. Sarley
811 Wellington Ave., Chicago 60657
STAFF: Mel Sloan

Responsibilities and Purposes

The Committee shall cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, implement the Impartial Medical Testimony panel.

ADVISORY COMMITTEE TO INTERPROFESSIONAL GROUPS
(Council on Public Relations)

James D. Majarakis, *Chairman*
30 N. Michigan Ave., Chicago 60602
Lawrence J. Bowness
9135 S. Exchange Ave., Chicago 60617
Walter J. Reedy
814 Washington St., Waukegan 60085
George Callahan
4 S. Genesee St., Waukegan 60085
Eugene L. Vickery
202 S. Schuyler St., Lena 61048
David Whitsell
2441 W. 79th St., Chicago 60652

CONSULTANTS:
Caesar Portes
25 E. Washington, Chicago 60602
E. A. Piszczek
6410 N. Leona St., Chicago 60646
STAFF: Gary Kennon

Responsibilities and Purposes

This committee shall maintain general liaison with the officers and members of other professions, conduct programs and activities which will enhance the relationship between the professions. It shall serve especially to provide liaison with the Interprofessional Council.

JOURNAL (PUBLICATIONS) COMMITTEE
(Board of Trustees)

Jacob E. Reisch, *Chairman*
1129 S. 2nd St., Springfield 62704
J. Ernest Breed
55 E. Washington St., Chicago 60602
Darrell H. Trumpe
St. John's Sanatorium, Springfield 62707
Warren W. Young
10816 Parnell Ave., Chicago 60628
STAFF: Richard A. Ott
STAFF ADVISOR: Roland I. King

Responsibilities and Purposes

The Journal (Publications) Committee shall be composed of members of the Board of Trustees, and shall be responsible for the production of the Illinois Medical Journal and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

EDITORIAL BOARD

Sub-Committee of Journal Committee

Edwin F. Hirsch, *Chairman*
5830 Stony Island Ave., Chicago 60637
James H. Hutton
67 E. Madison St., Chicago 60603
Samuel A. Levinson
3730 Lake Shore Dr., Chicago 60613
Charles Mrazek
1210 Robin Hood Lane, LaGrange Park 60525
C. J. Mueller
108 W. 4th St., Sterling 61081
Frederick Steigman
1825 W. Harrison St., Chicago 60612
Frederick Stenn
6400 S. Kedzie Ave., Chicago 60629
Arkell M. Vaughn
9012 S. Leavitt Ave., Chicago 60643
STAFF: Richard A. Ott

Responsibilities and Purposes

The responsibilities of this committee lie in the area of the editorial content of the Illinois Medical Journal, and it will function as a subcommittee of the Journal Committee. It shall make recommendations to the editor concerning the scientific content, regular features and subjects of special interest to the members. It shall serve as a review board for manuscripts which the editor believes require special medical evaluation. It shall assist the editor in any way possible to obtain and present medical manuscripts of the highest quality and maximum interest to the physicians of Illinois.

COMMITTEE ON LABORATORY EVALUATION
(Medical-Legal Council)

Grover L. Seitzinger, *Chairman*
812 N. Logan, Danville 61832
Ronald Jessen
5145 California, Chicago 60625
Jack Williams
130 E. Randolph, Chicago 60601
Hans Willuhn
1335 Charles St., Rockford 61108

CONSULTANT:
James B. Hartney
410 Lake St., Oak Park 60302
STAFF: Mel Sloan

Responsibilities and Purposes

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians, and encourage each county and district to establish evaluation committees.

COMMITTEE ON LEGISLATION
(See Council on Legislation and Public Affairs)

SUB-COMMITTEE, ADVISORY TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION
(See Advisory Committee to Paramedical Groups)

COMMITTEE ON MATERNAL WELFARE
(Council on Scientific Services)

Robert R. Hartman, *Chairman*
1515 Walnut St., Jacksonville 62650
Frederick H. Falls, *Chairman Emeritus & Special Consultant*
Box 47, River Forest 60305

District *Member and Alternate*
(alternates in italics)

1. William R. Larsen
13707 W. Jackson, Woodstock 60098
Hugh C. Falls
711 N. McKinley Rd., Lake Forest 60045
2. William J. Farley
710 Peoria St., Peru 61354
Donald M. Gallagher
Box 538, Granville 61326
3. Melvin Goodman
13826 Lincoln Ave., Dolton 60419
Charles F. Kramer
12647 Justine St., Calumet Park 60643
4. V. B. Adams
301 E. Jefferson, Macomb 61455
Ralph Gibson
416 St. Marks Ct., #410, Peoria 61603
5. William W. Curtis
100 W. Miller Rd., Springfield 62702
Donald M. Barringer
118 Walnut, Lincoln 62656
6. Robert R. Hartman
1515 Walnut St., Jacksonville 62650
Hubert L. Allen
1312 Delmar, Godfrey 62035
7. Paul A. Raber
149 W. King St., Decatur 62521
Hubert Magill
1170 E. Riverside, Decatur 62521
8. George E. Fagan
301 E. Springfield Ave., Champaign 61820
John C. Mason Jr.
715 N. Logan Ave., Danville 61832
9. Harry L. Lewis
104 S. Maple, Benton 62812
Donald R. Risley
319 Market St., Mt. Carmel 62863
10. James B. Stotlar
15 N. Walnut, Pickneyville 62274
Berry V. Rife
102 Lafayette, Anna 62906
11. John J. McLaughlin
1000 Jefferson St., Joliet 60435
Charles P. Westfall
172 Schiller St., Elmhurst 60126

CONSULTANTS:
John Louis
Hematology Section
Stritch School of Medicine
1400 S. First Ave., Hines, 60141

Donaldson F. Rawlings, Chief
Division of Preventive Medicine
500 State Office Building, Springfield 62706
William R. Roach
700 North Michigan, Chicago 60611
(Section Chairman OB-GYN)
Willard C. Scrivner
4601 State St., East St. Louis 62205
Augusta Webster
Northwestern University
707 N. Fairbanks Ct., Chicago 60611
Franklin D. Yoder
503 State Office Building, Springfield 62706
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID (Council on Medical Service)

Fred A. Tworoger, *Chairman*
4753 Broadway, Chicago 60640
Rex O. McMorris, *Vice-Chairman*
619 N. East Glen Oak Ave., Peoria 61603
Louis Arp, Jr.
1409 6th Ave., Moline 61265
Charles E. Baldree, Jr.
26 E. Washington St., Belleville 62220
James R. Cooper
1416 Maine St., Quincy 62301
Herbert Fine
110 N. Division, Carterville 62918
George F. Lull
2440 N. Lakeview, Chicago
George T. Mitchell
116 S. 5th St., Marshall 62441
Robert C. Muehrcke
518 N. Austin Blvd., Oak Park 60302
Frank B. Norbury
1515 W. Walnut St., Jacksonville 62650
Alphonse L. Robinson
104a N. Front, Mounds 62964
William Scanlon
654-1st St., LaSalle 61301
John H. Steinkamp
824 Van Buren St., Belvidere 61008
R. Kent Swedlund
112 N. Fourth St., Watseka 60970
CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Don B. Freeman

Responsibilities and Purposes

The Medical Advisory Committee meets at regular intervals with the staff of the Illinois Department of Public Aid to perform functions necessary to the operation of the medical program under public aid. The committee renders advisory decisions on matters of medical policy in the administration of the quality, quantity, and cost standards of the various public aid programs. The committee operates in conjunction with an established system of county medical advisory committees and serves as a final reviewing body. It provides a channel of communication between physicians and the Department of Public Aid and strives to foster mutual understanding and good relationships.

The committee's functions also include a continuing program of education of physicians to familiarize them with the administrative details of public aid programs.

SUB-COMMITTEE ON DRUGS & THERAPEUTICS

Robert C. Muehrcke, *Chairman*
518 N. Austin Blvd., Oak Park 60302
Joseph Cece
120 Oakbrook Center, Oak Brook 60521
Charles R. Frazer, Jr.
1401 Gaty Ave., East St. Louis 62201
Richard L. Landau
950 E. 59th St., Chicago
Kenneth Kessel
9042 W. 31st St., Brookfield
CONSULTANT:
Louis Gdalman, R.Ph.
1753 W. Congress St., Chicago 60612
STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes

The committee will operate as a sub-committee of the Advisory Committee to the Illinois Department of Public Aid and will continue to work with the department in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it will review them and present them to the Department of Public Aid when necessary. The committee will also consider other drug matters affecting the policy of the medical society.

MEDICAL ECONOMICS & INSURANCE
(Council on Medical Service)

Frederick Z. White, *Chairman*
723 N. 2nd St., Chillicothe 61523
Don Mitchell
140 E. Market St., McLeansboro 62859
H. P. Swartz
450 Kennedy Dr., Kankakee 60901
A. Everett Joslyn, Jr.
557 Keystone Ave., River Forest 60305
Lawrence J. Knox
600 E. Main St., Olney 62450
James B. Flanagan
10400 S. Western, Chicago
John M. Coleman
2015 E. 79th St., Chicago
Paul Van Pernis
1316 Charles St., Rockford 61107
STAFF: Don B. Freeman

Responsibilities and Purposes

The functions of the committee shall include its continuing review of the Tax Qualified Investment Program (Keogh); the Retirement Investment Program; the Group Disability Program; the Group Major Medical Program; and the Professional Liability Insurance Program. The committee shall continue to investigate various insurance programs that may serve to benefit members of the society.

The committee shall continue to assist in the administration of the presently sponsored disability program by performing the adjudication services provided for in the master contract.

Matters having an economic bearing on the practice of medicine, including fact-finding and research studies in the general field of medical economics, shall be brought before this committee for consideration.

This committee shall study insurance plans provided the membership of the Society, and shall make suggestions for changes, additions, and cancellation of policies.

COMMITTEE ON MEDICAL EDUCATION
(Council on Medical Education)

Morgan M. Meyer, *Chairman*
573 S. Lombard St., Lombard 60148
William F. Hubble
866 Citizens Bldg., Decatur 62523
Jerry Ingalls
502 Shaw Ave., Paris 61944
Mays C. Maxwell
4202 Bond St., East St. Louis 62207
R. Charles Oldfield, Jr.
40 S. Clay St., Hinsdale 60521
F. H. Riordan, III
6670 State St., Rockford 61108
Robert J. Schafer
404 W. Washington Ave., Petersburg 62675
REPRESENTATIVES OF MEDICAL SCHOOLS
Richard Landau, University of Chicago
950 E. 59th St., Chicago 60637
LeRoy Levitt, Chicago Medical School
2020 W. Ogden Ave., Chicago 60612
Edward S. Petersen, Northwestern University
303 E. Chicago Ave., Chicago 60611
Wm. B. Rich, Stritch School of Medicine
Loyola University 1400 S. 1st Ave.,
Hines 60141
Nicholas J. Cotsonas, Jr., University of
Illinois at the Medical Center
Box 6998, Chicago 60680
CONSULTANTS:
William E. Adams
55 E. Erie St., Chicago 60610
Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
STAFF: Perry L. Smithers

Responsibilities and Purposes

This committee shall (A) maintain a continuing interest in the recruitment of students, in the curricula of the medical schools and in postgraduate in-hospital training programs; (B) carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician; (C) encourage and implement the AMA-ERF program in Illinois; (D) study, evaluate and criticize the postgraduate programs of ISMS and other organizations; and (E) be available to advise and cooperate with the Department of Registration and Education of the State of Illinois.

COMMITTEE ON MEDICAL PRACTICE AND QUACKERY
(Medical Legal Council)

William G. McCarthy, *Chairman*
13826 Lincoln Ave., Dolton 60419
Elliott Parker,
1630 Fifth Ave., Moline, 61265
Wilson West,
7300 State, East St. Louis 62205
Ross Hutchinson,
126 E. Ninth, Gibson City 60936
Raymond B. Murphy,
R.R. 3 Box 19, Robinson 62454
STAFF: Mel Sloan

Responsibilities and Purposes

The committee shall concern itself with the illegal practice of medicine and other healing arts groups associated with unfounded claims for cure of disease. It shall cooperate with the legal authorities of the state (such as the office of the Attorney General and the Department of Registration and Education) in providing information and witnesses for the prosecution of violators of the law. It shall cooperate with the AMA's Department of Investigation and other agencies interested in this field.

MEMBERSHIP COMMITTEE
(Council on Public Relations)

Henry A. Holle, *Chairman*
160 N. LaSalle St., Chicago 60601
Joseph N. Bourque
1465-41st St., Moline 61265
Burton J. Soboroff
307 N. Michigan Ave., Chicago 60601
Andrew J. Sullivan
4258 W. 55th St., Chicago 60632
CONSULTANT:
H. Close Hesseltine
5807 S. Dorchester Ave., Chicago 60637

AUXILIARY REPRESENTATION:
Mrs. Sherman C. Arnold
2416 Brookwood Dr., Flossmoor 60422
STAFF: James Slawny

Responsibilities and Purposes

The responsibilities of this committee shall include the development of orientation courses for new members and such other projects as will encourage participation in both county and state medical society activities.

COMMITTEE ON MENTAL HEALTH
(Council on Scientific Services)

John R. Adams, *Chairman*
707 N. Fairbanks Ct., Chicago 60611
Milton C. Baumann
725-2nd St., Springfield 62704
E. Eliot Benezra
103 Haven St., Elmhurst 60126
Robert S. Daniels
950 E. 59th St., Chicago 60637
Irving Frank
135 S. Sacramento, Sycamore 60178
Richard J. Graff
204 Julie Dr., Kankakee 60901
John H. McMahan
8601 W. Main St., Belleville 62223
Walter P. Plassman
Box 552, Centralia 62801
Billie Harold Shevick
729-3rd Ave., Moline 61265

AUXILIARY REPRESENTATION:
Mrs. Thomas Tourlentes
Research Hospital, Galesburg 61401
STAFF: Perry L. Smithers

Responsibilities and Purposes

The responsibilities of this committee are as follows: It shall serve as a source of information on mental health matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall also cooperate with institutions and voluntary health agencies in disseminating information on mental health subjects to the profession and the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

COMMITTEE ON NARCOTICS & HAZARDOUS SUBSTANCES
(Council on Scientific Services)

Joseph H. Skom, *Chairman,* 707 N. Fairbanks Ct., Chicago, 60611
Richard B. Eisenstein, 6730 South Shore Dr., Chicago 60649
H. Frank Holman, 1509 Illinois Ave., East St. Louis 62201
Jerome H. Jaffee, Dept. of Psychiatry, 950 E. 59th St., Chicago 60649
Thaddeus L. Kostrubala, Room 526, 506 S. Wabash Ave., Chicago 60605
Kermit T. Mehlinger., 4901 S. Drexel Ave., Chicago 60615
David Slight, 25 E. Washington St., Chicago 60602
STAFF: Perry L. Smithers

Responsibilities and Purposes

The functions of the Committee on Narcotics and Hazardous Substances are: (1) study, research and dissemination of educational information on narcotics and hazardous substances to members of the medical profession; (2) to recommend acceptable measures for the control of distribution, the use and disposal of narcotics and hazardous substances, exclusive of radiation products but including poison control, and (3) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COMMITTEE ON NURSING
(Council on Public Relations)

W. I. Taylor, *Chairman*
28 N. Main St., Canton 61520
Raymond Firfer,
6846 W. Cermak Rd., Berwyn 60402
Roger Sondag
518 State Office Bldg., Springfield 62706
H. J. Kolb
303 Sherman, St. Joseph 61837
Luke R. Pascale
18668 Dixie Highway, Homewood 60430
CONSULTANT:
Willard C. Scrivner
4601 State St., East St. Louis 62205
AUXILIARY REPRESENTATION:
Mrs. Mitchell Spellberg
7408 S. Clyde Ave., Chicago 60649
STAFF: James Slawny

Responsibilities and Purposes

The major objective of this committee is to establish a close professional relationship between the medical and nursing professions for the improvement of the health care of the patient. It should work with representatives of the nursing organizations to obtain sound educational programs for nurses, to improve the working relationships of the doctor and nurse in the hospital, and to help establish work patterns for nurses in the hospital which utilize the full skill of the nurse for the care of the patient. The committee should also assist in programs to recruit more graduate nurses, registered nurses, practical nurses, nurses aids and other ancillary nursing personnel. It shall function as a sub-committee of the Advisory Committee to Paramedical Groups.

COMMITTEE ON NUTRITION
(Council on Scientific Services)

Paul A. Dailey, *Chairman,* 620 N. Main St., Carrollton 62016
Allan A. Filek, Box 870, Evanston 60204
Richard Icenogle, Box 188, Roseville 61473
Eugene P. Johnson, 22 W. Main St., Casey 62420
James Litsey, 1312 W. Delmar, Godfrey 62035
Harvey D. Scott, 800 W. State St., Jacksonville 62650
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall serve as a source of information on nutrition matters for the ISMS and evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on nutrition subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

SUB-COMMITTEE ON OCCUPATIONAL HEALTH
(See Committee on Public Health)

COMMITTEE TO STUDY OSTEOPATHIC PROBLEMS
(Board of Trustees)

William E. Adams, *Chairman,* 55 E. Erie, Chicago 60611
Charles K. Wells, 117 N. 10th St., Mt. Vernon 62864
Arthur F. Goodyear, 142 E. Prairie Ave., Decatur 62523
Paul P. Youngberg, 1520 Seventh St., Moline 61265
STAFF: Roger N. White

Responsibilities and Purposes

The responsibilities of this committee are to assist in developing rapport, cooperation with and an understanding of the osteopathic profession. Its findings in any specific instance shall be reported to either the Board of Trustees or the House of Delegates for consideration and action. The committee shall study and report on the present situation in Illinois in view of recent action by the AMA House, and keep the Board informed of any changes in relationship between the two professions.

ADVISORY COMMITTEE TO PARAMEDICAL GROUPS
(Council on Public Relations)

Thomas R. Harwood, *Chairman*
4902 Tollview Rd., Rolling Meadows 60008
Maynard I. Shapiro
7531 Stony Island Ave., Chicago 60649
Robert E. Lynn
209 Henry St., Alton 62002
William Mohlenbroch
108 N. 14th St., Murphysboro 62966
Edward J. Krol
4255 W. 63rd St., Chicago 60629
Burton M. Krimmer
5736 W. North Ave., Chicago 60639
Paul G. Theobold
1210 Towanda, Bloomington 61701
Allison Burdick, Jr.
5906 W. North Ave., Chicago 60639
CONSULTANTS:
E. A. Piszczek
6410 N. Leona, Chicago 60646
Carl Clark
225 Edwards St., Sycamore 60178
Casper Epsteen
25 E. Washington St., Chicago 60602
James B. Hartney
410 Lake St., Oak Park 60301
AUXILIARY REPRESENTATIVE:
Mrs. John W. Koenig
2518 Oakwood Dr., Olympia Fields 60461
STAFF: Gary Kennon

Responsibilities and Purposes

The Advisory Committee to Paramedical Groups serves as liaison between the Illinois State Medical Society and the Health Careers Council of Illinois, the Illinois Medical Assistants Association and the five Illinois chapters of the Student American Medical Association, and with any other such organizations developed in the future. It shall also advise and assist these organizations in the development of new financial resources needed to maintain their operations.

POLICY COMMITTEE
(Board of Trustees)

William E. Adams, *Chairman,* 55 E. Erie St., Chicago 60611
Arthur F. Goodyear, 142 E. Prairie Ave., Decatur 62523
Paul P. Youngberg, 1520 Seventh St., Moline 61265
STAFF: Frances C. Zimmer

Responsibilities and Purposes

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society.

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS (Council on Medical Service)

Preston S. Houk, Chairman
207 Parkview Dr., Bloomington 61701
C. P. Cunningham
2526 18th Ave., Rock Island
B. A. Kinsman
207½ E. Main St., DuQuoin 62832
Philip Lynch
1314 N. Main St., Decatur 62526
Theodore J. Wachowski
310 Ellis Ave., Wheaton 60187
James P. FitzGibbons
4753 N. Broadway, Chicago 60640

CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Don B. Freeman

Responsibilities and Purposes

The function of the committee is to provide a channel of communication between the health insurance industry, Blue Cross-Blue Shield Plans, and the Illinois State Medical Society on matters of mutual concern. Specific problems which may arise as a result of this liaison will be referred to appropriate committees for detailed study.

COMMITTEE ON PUBLIC AFFAIRS (Council on Legislation & Public Affairs)

Theodore Grevas, *Chairman* 1800 Third Ave., Rock Island 61201
Edward C. Albers, Christie Clinic, 104 W. Clark St., Champaign 61820
William F. Ashley, 6545 W. 33rd St., Berwyn 60402
William W. Boswell, 2500 N. Rockton Ave., Rockford 61103
Herschel L. Browns, 4600 N. Ravenswood Ave., Chicago 60640
James E. Coeur, 630 Locust St., Carthage 62321
Edwin L. Fallon, 9543 S. Central Park, Evergreen Park 60642
Justin Fleischmann, 320 South Ela Rd., Palatine 60067
George L. Gertz, 2376 E. 71st St., Chicago 60649
A. Z. Goldstein, Rosiclare 62982
P. H. Heller, 1173 Algonquin Rd., Des Plaines 60018
William J. Hillstrom, 280 Virginia Ave., Crystal Lake 60014
W. Robert Malony, Carbondale Clinic, Carbondale 62901
John W. Ovitz, Jr., 204 W. Elm St., Sycamore 60178
Paul A. Raber, 149 W. King St., Decatur 62521
James D. Rogers, 120 Scott St., Joliet 60531
Peter C. Rumore, 401 N. Mulberry St., Effingham 62401
Stanley E. Ruzich, 9944 Damen Ave., Chicago 60643
James H. Ryan, 1309 E. Court St., Kankakee 60901
John L. Savage, 723 Elm St., Winnetka 60093
Julius P. Schweitzer, 120 Oakbrook Mall, Oak Brook 60521
D. William Sherrick, 2325 Sylvan Rd., Springfield 62704
Eugene H. Siegel, 103 Haven Rd., Elmhurst 60126
Lorin D. Whittaker, 840 Jefferson Building, Peoria 61602
Herbert Sohn, 4640 N. Marine Dr., Chicago 60640
Frederick Weiss, 15318 Center, Harvey 60426

CONSULTANTS:
J. Ernest Breed, 55 E. Washington, Chicago 60602
Frank J. Jirka, Jr., 1507 Keystone, River Forest 60305
Philip G. Thomsen, 13826 Lincoln Ave., Dolton 60419

AUXILIARY REPRESENTATION:
Mrs. David Kweder, 1432 N. Sheridan Rd., Waukegan 60085
STAFF: Dan Morgan

Responsibilities and Purposes

The Public Affairs Committee is concerned with the political process as it pertains to medicine and public health. Within this broad context, appropriate education of the public is basic to continue health improvement in a free society. The electorate must make its wishes known to public officials.

The Public Affairs Committee shall strive to generate interest in the overall field of politics to enable the physician to participate effectively. Programs of public affairs orientation, political education and campaign characteristics will be undertaken to increase the effectiveness of the physician in public affairs.

COMMITTEE ON PUBLIC HEALTH
(Council on Scientific Services)

Edward A. Piszczek, *Chairman,* 6410 N. Leona, Chicago 60646
Kenneth G. Bulley, 1329 N. Lake St., Aurora 60506
Clifton Hall, 504 State Office Bldg., Springfield 62706
Edward C. Holmblad, 1350 Lake Shore Dr., Chicago 60610
John S. Hyde, 715 Lake St., Oak Park 60301
George H. Irwin, 1791 Howard, Chicago 60626
David F. Lowen, 400 W. Hay St., Decatur 62526
Robert J. Maganini, 727 W. Hickory St., Hinsdale 60521
Karl H. Pfuetze, 55 & County Line Rd., Hinsdale 60521
Arthur E. Sulek, 2710 Bradley Rd., Rockford 61107

CONSULTANT:
Warren W. Young, 10816 Parnell Ave., Chicago 60628

STAFF: Perry L. Smithers

Responsibilities and Purposes

The Committee on Public Health shall cooperate with the Illinois Department of Public Health in certain specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on tuberculosis and cooperate with institutions and voluntary health agencies in disseminating such information.

The committee should encourage the establishment of county or multi-county health units, work with the state department in immunization programs or specific programs designed to diagnose and refer certain communicable diseases.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth; urbanization and technological developments bearing on the ecology of man.

The committee also shall be concerned with diseases and problems associated with occupational and industrial health; cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the Board in the evaluation of claims.

COMMITTEE ON PUBLIC RELATIONS
(Council on Public Relations)

Matthew B. Eisele, *Chairman*
4601 State St., East St. Louis 62205
William H. Harridge
636 Church, Evanston 60201
Charles S. Vil
9450 S. Francisco St., Evergreen Park 60642
Charles J. Weigel
7579 Lake St., River Forest 60305
Lee F. Winkler
850 S. Fourth St., Springfield 62703

CONSULTANTS:
Jacob E. Reisch
1129 S. Second St., Springfield 62704
Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936
Leo P. A. Sweeney
2658 W. 95th St., Evergreen Park 60642

STAFF: James Slawny

Responsibilities and Purposes

The Committee on Public Relations shall consist of five members appointed by the Board of Trustees.

It shall plan and execute programs designed to enhance the relationship between the public and the medical profession. It shall request the Board of Trustees to appoint sub-committees to accomplish specific purposes.

COMMITTEE ON PUBLIC SAFETY
(Council on Public Relations)

Edwin A. Lee, *Chairman*
501 S. 13th St., Springfield 62703
James P. Campbell
322 N. Blanchard St., Wheaton 60187
Julius M. Kowalski
436 Park Ave., East, Princeton 61356
Norman J. Rose
400 S. Spring St., Springfield 62706
Clifford P. Sullivan
2800 W. 87th St., Chicago 60652
Donald S. Miller
6 N. Michigan, Chicago 60602

AUXILIARY REPRESENTATION:
Mrs. Arthur A. Smith
206 Country Club Lane, Belleville 62223

STAFF: Gary Kennon

Responsibilities and Purposes

The Committee shall study the medical aspects of accident prevention; alert the public to seasonal health hazards; and co-operate with the Illinois Department of Public Health, the National Safety Council and similar organizations. It shall function as a sub-committee of the Committee on Disaster Medical Care.

COMMITTEE ON RADIATION
(Council on Scientific Services)

Howard C. Burkhead, *Chairman*
130 Dempster St., Evanston 60201
Abram H. Cannon,
194 Michael John Dr., Park Ridge 60068
Stephen L. Casper,
1101 Maine St., Quincy 62301
J. Homer Goodlad,
221 N. E. Glen Oak Ave., Peoria 61603
Stuart P. Lippert,
7 Pitner Pl., Jacksonville 62650
Howard C. Neucks,
602 W. University, Urbana 61801
James J. Nickson,
2900 S. Ellis Ave., Chicago 60616
Hyman R. Osheroff,
420 S. Harlem, Freeport 61032
Norman R. Shippey,
4601 State St., East St. Louis 62205
Raymond B. White,
9333 S. Damen Ave., Chicago 60620
CONSULTANT:
J. Ernest Breed
55 E. Washington St., Chicago 60602
Carl E. Clark
225 Edwards St., Sycamore 60178
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall serve as a source of information on radiation matters for ISMS and evaluate available information and make recommendations to the Board for the position ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on radiation subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

COMMITTEE ON REHABILITATION SERVICES
(Council on Scientific Services)

Henry B. Betts, *Chairman,*
401 E. Ohio St., Chicago 60611
Eli L. Borkon,
Box 1030, Carbondale 62901
Bruce C. Ehmke,
Suite 1112, 411 Hamilton Blvd., Peoria 61602
John E. Finch,
135 S. Kenilworth, Elmhurst 60126
Frank B. Kelly, Jr.,
122 S. Michigan Ave., Chicago 60603
Joseph L. Koczur,
9143 S. Ashland Ave., Chicago 60620
John G. Meyer,
413 W. Monroe, Springfield 62704
Arthur A. Rodriquez,
9145 S. Ashland Ave., Chicago 60620
CONSULTANT:
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall render assistance to public and private agencies in the establishment of policies regarding rehabilitation facilities to be used and selection of patients for these services; encourage the training of rehabilitation personnel, thereby promulgating high quality care; and assist when possible to see that adequate medically supervised rehabilitation services be made available in all hospitals, according to the need of the hospitals.

The committee shall also provide liaison between the ISMS and the Division of Vocational Rehabilitation, the Department of Public Aid, and other official or non-official agencies which purchase rehabilitation care for patients. The committee also works closely with the Governor's Committee on Employment of the Handicapped when called upon for its advice and counsel.

SUB-COMMITTEE ON RELATIVE VALUE
(See Committee on Medical Economics & Insurance)

COMMITTEE ON RELIGION & MEDICINE
(Council on Public Relations)

Robert S. Mendelsohn, *Chairman*
1100 Hull Terrace, Evanston 60202
Anna A. Marcus
5852 W. North Ave., Chicago 60639
Charles W. Pfister
5511 N. Harlem Ave., Chicago 60656
Paul S. Rhoads
814 Roslyn Terrace, Evanston 60621
The Very Rev. Msgr. Armand J. Rotondi (M.D.)
504 Lockport, Plainfield 60544
William H. Whiting
Box 410, 525 N. Main St., Anna 62906
Rabbi E. H. Prombaum
5030 N. Hamlin, Chicago 60625
Rev. John Marren
916 S. Wolcott, Chicago 60612
Rev. Christian Hovde
116 S. Michigan Ave., Chicago 60603
CONSULTANTS:
J. Ernest Breed
55 E. Washington St., Chicago 60602
Caesar Portes
25 E. Washington St., Chicago 60602

AUXILIARY REPRESENTATION:
Mrs. Sherman C. Arnold
2416 Brookwood Dr., Flossmoor 60422
Mrs. John W. Koenig
2518 Oakwood Drive, Olympia Fields 60461
STAFF: James Slawny

Responsibilities and Purposes

The committee is responsible for the development of effective lines of communication between the physicians and the clergymen leading to the most effective care and treatment of the patient and his family.

COMMITTEE ON RURAL HEALTH & STUDENT LOAN FUND
(Council on Medical Education)

Jack Gibbs, *Chairman*
24 Main St., Canton 61520
Charles N. Salesman
1201 N. Allen St., Robinson 62454
Donald L. Stehr
102 E. Market St., Havana 62644
CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Roland I. King

Responsibilities and Purposes

The committee shall be responsible to the Board of Trustees in matters related to improving the standards of health in rural areas and with administration of the Student Loan Program operated jointly with the Illinois Agricultural Association to induce physicians to practice in rural areas. Members of the committee shall be appointed by the Board for terms of one year. The committee shall work closely with the Illinois Agricultural Association in efforts to improve the standard of health in farm areas.

COMMITTEE ON SCIENTIFIC ASSEMBLY
(Council on Medical Education)

Robert T. Fox, *Chairman*
2136 Robin Crest Lane, Glenview 60025
J. Robert Thompson, *Director of Exhibits*
1129 N. Elmwood Ave., Oak Park 60302
Coye C. Mason, *Assistant Director of Exhibits*
2056 N. Clark St., Chicago 60614
George E. Block
950 E. 59th St., Chicago 60637
John J. Brosnan
9156 S. Francisco, Evergreen Park 60642
Robert R. Fahringer
1230 S. 6th St., Springfield 62706
Charles P. McCartney
5841 S. Maryland, Chicago 60637
Harold P. McGinnes
2304 E. Oakland Ave., Bloomington 61701
Donald L. Unger
185 N. Wabash Ave., Chicago 60601
AUXILIARY REPRESENTATION:
Mrs. John Van Prohaska
5830 S. Stony Island Ave., Chicago 60637
Mrs. Maurice Goldstein
6853 N. Hiawatha Ave., Chicago 60646
STAFF: Perry L. Smithers

Responsibilities and Purposes

The Committee on Scientific Assembly shall consist of nine members appointed by the Board of Trustees. It shall coordinate the programs for the general assemblies; the section meetings and the scientific exhibits at the annual convention; shall appoint, with the approval of the Board, a secret committee to make awards to the scientific exhibitors; may incorporate in the annual scientific meeting those meetings of medical specialty groups which wish to affiliate with the ISMS annual convention, and shall arrange for the annual banquet and other functions held during the annual convention.

SCIENTIFIC MEETINGS

(A) with the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of the ISMS (B) for the transaction of scientific business, there shall be one or more sections as may be determined from year to year by the Board of Trustees (C) section officers shall be appointed by the president of the Society from nominees recommended by the section, or if there are no nominees, from a list submitted by the Chairman of the Committee on Scientific Assembly (D) the officers of the sections shall arrange the scientific program for the section in cooperation with the committee (E) all registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings (F) the general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public (G) all papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of the paper in the ILLINOIS MEDICAL JOURNAL shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published (H) The Board of Trustees shall be entirely responsible for the annual convention.

SCIENTIFIC SECTION CHAIRMEN

ALLERGY
Donald B. Frankel
111 N. Wabash Ave., Chicago 60601

DERMATOLOGY
Malcolm C. Spencer
605 N. Logan Ave., Danville 61832

EYE, EAR, NOSE and THROAT
E. M. Skolnick
64 Old Orchard, Skokie 60076

INTERNAL MEDICINE
Angelo P. Creticos
67 E. Madison St., Room 1505 Chicago 60603

NEUROLOGY & PSYCHIATRY
David Swanson
Dept. of Neurology & Psychiatry
Stritch School of Medicine
1400 S. 1st Ave., Hines 60141

OBSTETRICS and GYNECOLOGY
William R. Roach
700 N. Michigan Ave., Chicago 60611

PATHOLOGY
Elizabeth A. McGrew
1853 W. Polk St., Chicago 60612

PEDIATRICS
Ira M. Rosenthal
700 S. Wood St., Chicago 60612

PHYSICAL MEDICINE and REHABILITATION
W. T. Liberson
VA Hospital, P.O. Box 28, Hines 60141

PREVENTIVE MEDICINE & PUBLIC HEALTH
Roger F. Sondag
518 State Office Bldg., Springfield 62706

RADIOLOGY
Richard E. Buenger
1753 W. Congress Parkway, Chicago 60612

SURGERY
Roderick H. Maguire
106 Martin Ave., Canton 61520

SUB-COMMITTEE, ADVISORY TO STUDENT AMERICAN MEDICAL ASSOCIATION
(See Advisory Committee to Paramedical Groups)

SUB-COMMITTEE ON TUBERCULOSIS
(See Committee on Public Health)

COMMITTEE ON USUAL AND CUSTOMARY FEES
(Board of Trustees)

Joseph R. O'Donnell, *Chairman*
444 Park Blvd., Glen Ellyn 60137

W. C. Scrivner
4601 State St., East St. Louis 62205

James B. Hartney
410 Lake St., Oak Park 60302

J. Mather Pfeiffenberger
State & Wall Sts., Alton 62004

Joseph L. Bordenave
1665 South St., Geneva 60134

STAFF: James Slawny

Responsibilities and Purposes

The Committee on Usual & Customary Fees was appointed by the Board of Trustees to define the concepts of usual, customary, and reasonable fees, and to develop guidelines for the implementation of these concepts at the county, district, and state society level. In carrying out the directive that physicians be reimbursed on the basis of their usual and customary fees without reference to existing fee schedules, the committee meets with representatives of health insurance carriers, government intermediaries, and government agencies who pay for medical services, and reviews the adequacy and appropriateness of physician reimbursement in accordance with the position of the Board of Trustees and the House of Delegates.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY
(Board of Trustees)

Edward W. Cannady, *Chairman*
4601 State St., East St. Louis 62205

Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419

Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305

STAFF: Roger N. White

Responsibilities and Purposes

The committee shall consist of the president-elect as chairman, the president, the chairman of the board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

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ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate the standards of medical education
- to unite the medical profession behind these purposes, and
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Business Services; Public Relations and Economics; Legislation and Public Affairs, Publications, and Educational and Scientific Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors, and still others are sponsored for specific groups or individuals.

Following are descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

In order to provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions. The Division of Administration provides many important functions.

This Division maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function.

The controlling factor in all these areas is the Constitution and Bylaws. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action.

The Division, through the Administrator, channels all legal inquiries and works with the General Legal Counsel and the Special Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The duties and responsibilities of the Executive Administrator are of utmost importance, and are outlined in the Bylaws of the Society.

DIVISION OF BUSINESS SERVICES

Just as the entire staff of the Illinois State Medical Society exists to serve the needs of more than 10,000 members, the Division of Business Services exists to serve the needs of the other staff divisions. Specifically, all mail room and central-supply services are provided by the division.

Membership records are maintained so that quick access may be had to correct information concerning the basic membership history of each of our members. In addition, forms to obtain dues, address changes and other necessary information are designed and supplied to each county society secretary for his use.

Electronic Data Processing

The Business Services Division has primary responsibility for development of computer processing service for ISMS administrative requirements. Membership dues billing, collection and reporting service is already available to county societies that desire the service, and mailing of the Society's membership publications will be handled by computer in the near future. The 1967 Reference Committee on the Opinion Research Survey recommended incorporation of modern data processing in support of administrative and membership programs. Special research and study is being devoted by the Business Services Division to provide the information and data resources necessary to retain Illinois leadership in the world of organizational medicine.

Committees

The Committees on the Annual Leadership Conference and Rural Health and Medical Student Loan Fund are assigned to this division for the staff services which might be required. The Advisory Committee to the Annual Leadership Conference has responsibility for developing an enlightening program which will help county society leaders find better ways to serve both the public and their county society membership more effectively. The Rural Health and Medical Student Loan Fund Committee co-administers the joint Illinois State Medical Society/Illinois Agricultural Association Medical Student Loan Fund Program. Since its inception in 1948 the program has helped over 125 qualified applicants to hurdle financial or borderline academic barriers to a medical education. The objective of the program

is to provide an incentive to the prospective medical students to enter family practice in the areas in Illinois that are in need of new physicians to serve their rural communities.

Accounting and Budget

Responsibility for providing safekeeping and proper accounting for all money and securities of the Society rests with this division, upon the direction and guidance of the Board of Trustees Finance Committee, the Secretary-Treasurer, and the Executive Administrator. Assistance is offered to all interested staff and officers in the interpretation of the division's regular and special accounting and budgetary reports.

Liaison with outside agencies in regard to matters affecting the finances of the Society is a prime responsibility of this division; the Internal Revenue Service, the Society's banking and investment agencies, office building rental agent, and the American Medical Association are major examples.

Advertising

Within the Illinois Medical Journal, and for the publications *Pulse* and *What Goes On,* commercial advertising is carried. The maintenance of the records of advertisers, insertions, contracts, and direct communication with advertising agencies fall within the purview of the division. Through the division and its representatives the opportunity of presenting a product to members of ISMS through advertising in our publications is offered.

Insurance Coverage

Provision for and maintenance of the Society's property, liability, and employee insurance coverages are handled within this division, so that legal and financial requirements are satisfied at the most economical premium cost. In this area of responsibility, the assistance and cooperation of the Division of Economics and Insurance are utilized in order that best results for the Society may be obtained.

Standardization of office procedures and systems in order to reduce the cost and raise the efficiency of the office operation is a continuing assignment for the division. Assistance in personnel recruitment, job analysis, and salary range administration is provided to the Executive Administrator and other division directors.

DIVISION OF LEGISLATION AND PUBLIC AFFAIRS

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Council on Legislation acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. This program, executed by the Division of Legislation and Public Affairs, as directed by the ISMS Public Affairs Committee, strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

Divisional activities also includes other services. One of these, involving medicine, law, and the judiciary, is the administration of the Impartial Medical Testimony program. Operating in conjunction with the Supreme Court of Illinois and the Federal District Court, the services of impartial medical examiners are provided in personal injury cases.

Other facets of medical-legal interaction are explored through the Medical-Legal Council and problems resolved through liaison with committees of the judicial and the bar associations.

In addition to the foregoing, the division staffs the Committees on Laboratory Evaluation, Medical Practice and Quackery and the Eye Committee.

DIVISION OF PUBLICATIONS

All publications of the Society, including the *Illinois Medical Journal,* are produced through this division. The Journal, the official publication of the Society, is mailed monthly to all members, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state. The editor welcomes suggestions for articles which may be of special interest to members.

Other publications are *Pulse,* a monthly newsletter, and *What Goes On In Illinois,* a calendar of events of medical interest.

This division provides staff services for the Publications Committee and the Editorial Board.

Within the division, responsibility is taken for all printing and duplicating services for the society; a small print shop is maintained along with modern reproduction and collating equipment.

DIVISION OF EDUCATIONAL AND SCIENTIFIC SERVICES

Committee Responsibilities

This division provides staff services for the Council on Scientific Services, the Council on Medical Education and the 15 committees assigned to these councils.

Annual Convention

Similarly, the staff serves as an arm of the Committee on Scientific Assembly to arrange and produce the annual convention of ISMS. Held in May in Chicago each year, the convention offers scientific meetings and exhibits as well as sessions of the House of Delegates.

An additional function of the division is to administer the affairs of the Educational and Scientific Foundation, a non-profit organization established to conduct educational and scientific projects related to medicine. Physicians are invited to become Fellows of the Foundation for a charter membership of $100.

DIVISION OF PUBLIC RELATIONS AND ECONOMICS

The Public Relations and Economics Division serves both as a news outlet to the lay press, and as a source of supply for information on socio-economic and insurance matters to the membership.

With increasing frequency, the division is contacted by news writers seeking information on socio-economic, as well as scientific subjects. Its counseling services on public relations and publicity are available to any county medical society.

The division is also frequently called upon to prepare speeches, write and publish pamphlets and other materials and make them available for distribution on such subjects as public aid in Illinois, medical care financing through Social Security, and physician retirement programs.

So far as it is possible to do so, the division designs and directs research in the area of economics. Such projects have included the Relative Value and the Membership Fee Surveys.

News Releases

A mailing list of all Illinois newspapers, radio and television stations is maintained by the division. The list is so arranged that news releases may be addressed to individual counties, and county society secretaries may avail themselves of this service.

News releases for county societies are automatically prepared by the division staff and distributed to all news outlets in the particular county whenever a county society makes use of the ISMS post-graduate education program. Other than this, the state society's staff does not prepare news releases of county society activities unless this service is specifically requested.

Health Columns for Newspapers

Currently, ISMS presents weekly and daily public service health columns entitled "Dr. SIMS Says." These columns, offered to the 700 newspapers in Illinois, carry the logotype of Dr. "SIMS" which readily identifies the column with the Illinois State Medical Society.

Another public service column, being carried by some 300 high school newspapers throughout Illinois, is entitled "Dr. SIMS Talks to Teens." It is distributed on a monthly basis.

Public Aid Liaison

Familiarity with the medical care programs of the Illinois Department of Public Aid and liaison with the staff of the department are other responsibilities of the Division of Public Relations and Economics. Liaison is also maintained with public and private agencies interested in the fields of aging, insurance, hospitals, and rehabilitation.

Periodically, information is prepared for physicians and the public pertaining to such medical care programs as Old Age Assistance, Aid of the Medically Indigent, and the Military Dependents' Medical Care.

The division provides staff services to the Councils on Medical Services and Public Relations, as well as the committees on: Religion and Medicine, Membership, Disaster Medical Care, Public Safety, Hospital Relations, Prepayment Plans, Medical Economics and Insurance, Drugs and Therapeutics, Aging, and Public Relations.

Also provided with staff services are advisory committees to: Paramedical Groups, Inter-Professional Groups, and the Illinois Department of Public Aid.

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

FILMS

Stroke—Early Restorative Measures in Your Hospital

A film entitled "Stroke—Early Restorative Measures in Your Hospital," produced by the ISMS Committee on Aging, is available from the Society.

Directed toward physicians in all general hospitals, regardless of size, the film illustrates simple and effective methods and devices used in the rehabilitation of stroke patients. It emphasizes the procedures to be instituted immediately upon the patient's admission to the hospital.

Primary purpose of the film is to inform physicians and nurses of the need for immediate action in stroke cases and to interest them in acquiring additional details for treatment through available publications or study courses. The 20-minute sound, color film illustrates a program of constructive rehabilitation which may be conducted in any hospital, however small, by an interested nurse using a minimum of equipment.

The film may be obtained from the Society on a loan basis for viewing without charge or may be purchased for $125.

Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for any physician faced with the management of multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identicality was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

SPECIAL PUBLICATIONS

What Goes On in Illinois

What Goes On in Illinois is a calendar of medical and scientific meetings conducted in Illinois and adjacent states. It contains information about conventions, medical meetings, seminars and short courses conducted by educational institutions, hospitals, specialty societies, and voluntary health organizations. Published by the Illinois State Medical Society under a grant from Lederle Laboratories, *What Goes On in Illinois* is mailed to all doctors in Illinois and other interested persons nine times a year. Combined issues are published in May-June, July-August, and November-December.

Program chairmen of organizations or institutions sponsoring scientific meetings open to medical and paramedical personnel outside of their own membership are invited to submit pertinent information to *What Goes On In Illinois,* c/o the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Deadline for copy is 35 days in advance of publication.

Pulse

Pulse is a monthly newsletter published by the Illinois State Medical Society under a grant from Roche Laboratories, Division of Hoffmann La-Roche, Inc. It is distributed to all doctors in the state, to members of the Woman's Auxiliary and Illinois Medical Assistants Association, and is supplied in quantity to hospitals for interns, residents and other personnel.

Pulse carries non-scientific news, photographs and feature materials of interest to the medical profession in Illinois. A special section is devoted to the activities of the Woman's Auxiliary.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending physicians forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim

purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

1) When a physician receives a form from an insurance company bearing the HIC symbol it should be completed and returned to the company.
2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.
3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations and Economics while the supply lasts.

Disaster Hospital Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing disaster plans, the ISMS Committee on Disaster Medical Care has adopted a model emergency plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paper back book entitled "Horizons Unlimited" is available from the Society.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a $50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the chairman of the Committee on Continuing Education, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIANS PLACEMENT & STUDENT LOAN FUND PROGRAM

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 400 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 150 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois State Health Department and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

Illinois Medical Student Loan Fund Program

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician but lack sufficient financial resources or a recommendation for medical school. Since its inception in 1948, the program has helped over 125 qualified applicants to hurdle financial or borderline academic barriers to a medical education.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans of $625 per semester—up to a total of $6,250 over a five-year period. A two per cent interest rate is charged semi-annually from the time the loan is received. The borrower must also insure himself for the entire amount of the loan and pay premiums on the policy. However, he has four years after receipt of his M.D. degree before the first principal payment is due.

The program also offers assistance to those who may not have financial difficulties but can't get into a "Class A" medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend 10 candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town—serving a rural population for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities in Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a male premedical student of at least three years college standing . . . an Illinois resident outside of Cook County . . . and that he take a medical college admissions test for review by the program's board.

The board of the Medical Student Loan Fund Program conducts its annual interview about Dec. 1 for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Medical Student Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was

established by the introduction of Illinois Supreme Court Rule 17-2 in September 1961.

In the new Supreme Court Rules which became effective January 1, 1967, the use of IMT examiners is authorized by Rule 215 (d) (1). A substantial change was made in the Rule to allow the use of IMT examiners in any "proper" case. The Rule formerly was limited to personal injury actions. The new Rule states: "(1) a reasonable time in advance of the trial, the court may on its own motion or that of any party order an impartial physical or mental examination of a party whose mental or physical condition is in issue, when in the court's discretion it appears that such an examination will materially aid in the just determination of the case. The examination shall be made by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society.

(2) *Examination During Trial.* Should the court at any time during the trial find that compelling considerations make it advisable to have an examination and report at that time, the court may in its discretion so order.

(3) *Copies of Report.* A copy of the report of examination shall be given to the court and to the attorneys for the parties.

(4) *Testimony of Examining Physician.* Either party or the court may call the examining physician or physicians to testify. Any physician so called shall be subject to cross-examination.

(5) *Costs and Compensation of Physicians.* The examination shall be made, and the physician or physicians, if called, shall testify, without cost to the parties. The court shall determine the compensation of the physician or physicians.

(6) *Administration of Rule.* The Administrative Director and the Deputy Administrator Director are charged with the administration of the rule."

Illinois is distinquished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois. The IMT examiners are selected from the panel in rotating sequence.

When the program was begun in 1961, the IMT examiners were to be paid, on court approval of bills submitted, by the Illinois State Bar Association Foundation, which was the custodian and disbursing agent of a special IMT fund. This fund had been made possible by grants from the Ford, Wieboldt, Deere, Woods and Lilly Foundations. At that time, it was anticipated that the State would later assume the obligation of financing this program. As of July 1, 1967, the State assumed the financing as part of its regular court budget, and as of that date the funds have been disbursed by the Administrative Office of the Court.

In an appropriate case, the plan evolves as follows:

1) judge invokes Rule 215 (d) (1) (when in his judgment introduction of an IMT examiner will aid materially in the equitable disposition of the case);
2) judge contacts supreme court administrator, requesting IMT examiner (special forms are used for this purpose);
3) court administrator contacts Illinois State Medical Society for IMT examiner, as required by the character of the injury;
4) ISMS selects an IMT examiner from the panel of the medical specialty relating to the injury involved;
5) ISMS relates the identity of the IMT examiner to the court administrator;
6) court administrator schedules the examination of the plaintiff, and obtains pertinent medical records for the IMT examiner.
7) IMT physician examines plaintiff, and prepares medical report. This report is submitted to the court. Copies are prepared for the attorneys involved.
8) IMT examiner is available for court testimony, as required.
9) IMT examiner submits bill to the Administrative Office of the Court.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

INSURANCE PROGRAMS

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The group annuity and mutual fund portion of the program may also be used as funding vehicles for Keogh qualified investment if so desired. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet

the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recesison or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing so he not only receives advantages he would not otherwise have but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Program* making available the group annuity at a substantial reduction in premium, and the mutual funds, offered without sales commission load, is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The Continental Illinois National Bank and Trust Co. of Chicago receives all physicians' contributions, and maintains records.

Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance, is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

Mutual Fund

The no load open end mutual fund, consisting primarily of common stocks, is managed by Stein Roe & Farnham of Chicago, which has been serving as investment adviser to pension and profit sharing trusts, trustees, individuals, and other investors since 1932.

The Stein Roe & Farnham Stock Fund is quoted daily in most major newspapers and the *Wall Street Journal.* The fund has no sales commissions. The investment adviser receives a quarterly management fee of ⅛ of 1 per cent of the average net asset value of the fund. Management fees are common to all mutual funds and are distinct from sales loads.

Group Disability Program

The Illinois State Medical Society has officially approved a group disability program which is available to all eligible members of the ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

The $15,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a $500 or $1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to $30 a day and up to $45 a day in an intensive care unit. It will pay $20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to $2,000 for dependents. It will also cover a congenital anomaly from the first day of birth after the effective date of the contract up to $2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society, Division of Public Relations and Economics.

Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the *Society's Tax-Qualified Retirement Program,* which utilizes a Continental Assurance Company Group Annuity and the Stein Roe & Farnham Stock Fund. This Program is intended for members who may find the provisions of the Keogh Act to their advantage. A recent liberalization, effective in 1968, which will allow contributions made by self-employed physicians to be fully deductible is expected to make this Program more attractive to the membership. The principal provisions of the Koegh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or $2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full time employees with three or more years service under the Plan. A full time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

Continental Illinois National Bank & Trust Company of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physicians' contributions and maintains the Program's records.

Members wishing additional information on the Retirement Investment Program and the Tax-Qualified Retirement Program may write the Illinois State Medical Society, Division of Public Relations and Economics, 360 N. Michigan Ave., Chicago 60601.

PROFESSIONAL LIABILITY PROGRAM

An ISMS-sponsored professional liability insurance (malpractice) program became available to members June 1, 1968 after it was approved by the Board of Trustees and the State of Illinois Insurance Department. Members may enroll in it at any time.

The program was devised as an answer to physicians' complaints of arbitrary policy cancellations due to high-risk specialty or age, abrupt increases in premium rates and headlong out-of-court settlements.

Underwriter of the program is Employers' Group of Insurance Companies, 82-year-old Boston firm which had been highly commended as underwriter of the Florida Medical Society's malpractice plan. The administrator is Parker, Aleshire & Company, Skokie, which has served ISMS on other insurance since 1946.

Here are some key features of the program:

1. Coverage is available regardless of age or type of specialty.
2. ISMS directly supervises and controls the program, in conjunction with the administrator and underwriter. No policy will be declined or cancelled without just cause and a review by an ISMS designee. Any proposals for premium-rate increases, or other changes, will be submitted to the Economics and Insurance Committee for review and acceptance.
3. Firm steps are being taken to improve the legal climate in Illinois. No claims will be settled without the written approval of the insured. Outstanding defense counsels, expert in malpractice cases, will be retained. The legal profession will be notified that every nuisance claim will be fought. An educational program among the members will emphasize claim-prevention techniques and malpractice trends.
4. Coverage up to $1,000,000 is available.
5. Premium rates are in line with those charged by other insurers. A better legal climate will help stabilize the rates, because these will reflect the loss experience as it occurs in Illinois.

Scores of members applied for the coverage immediately after it was announced. Employers' Group hopes to have at least 4,000 members enrolled within five years, to assure the program's optimum strength and success.

Full details and application forms may be obtained from Parker, Aleshire & Company, 9933 North Lawler, Skokie, Ill. 60076.

RADIO-TV PUBLIC SERVICE MATERIALS

Radio materials available from the Illinois State Medical Society include:

1) "Today's Health Tip"—a new 30-second health message every day. Available on records (30 messages per record) which feature the voice of Dr. "SIMS." For added local appeal scripts are also available which can be read by local announcer or physician.

2) "Medical Interview"—a five minute weekly interview series featuring a different doctor each week, discussing subjects on practical health matters in language the layman can understand.

3) "Medicine, Morals and You"—an 11-part, half hour series combining a pre-taped dramatic introduction and live interviews with physicians and clergymen who discuss

such vital medical-moral issues as: abortion, narcotics addiction, contraceptive pills, suicide, and the unwed mother.

Television materials currently include one-minute animated spots on the subjects of measles, arthritis quackery, pre-school examinations, and rheumatic fever. Subsequent spots stressing preventive medicine will be produced during the course of the year.

In addition, the Division of Public Relations maintains a radio and television speakers' bureau, which obtains physician-speakers for radio and television interview shows on request.

Doctor's Responsibility to the Press

Physicians and the press are partners in providing a line of communication between the medical profession and the public. But, the press cannot carry out its traditional responsibility in informing the public in the area of medical and patient news without the cooperation of the medical society and individual doctors. The inevitable penalty of silence by the doctors is public ignorance, misunderstanding and fear. In a democracy, public ignorance, misunderstanding and fear can be dangerous to professional freedom.

The following outline—based on a press code adopted by the Macon County Medical Society—is suggested as a pilot guide for individual physicians and county societies in Illinois.

Availability

1) The officers, committee chairmen or designated spokesmen of county medical societies shall be available at all times to mass media personnel to provide authentic information on medical subjects.

2) A list of current spokesmen shall be supplied by county societies to the executives of every newspaper, radio and television station in the country.

3) These spokesmen may be quoted by name. They should not be considered by their colleagues as self-seeking, since authoritative attribution is done in the best interests of the public and the profession. (In addition, physicians are private citizens and as such are the subjects of news stories in their social and civic activities just like any other citizen.)

Physician News

Physicians, as scientists, are encouraged to give newspaper interviews and appear on radio and television programs on medical subjects. Physicians may report on new or unusual diseases or treatments within an ethical framework. In these instances, they should, whenever possible, notify their county society publicity chairman or the Illinois State Medical Society.

Physicians may be asked to comment as individuals on politically controversial subjects (such as socialized medicine). In this event, the physician should clearly indicate that he is expressing his personal viewpoint which should not be construed as a statement of medical society policy.

A medical society officer, however, should remember that any comment he makes—whether or not intended as personal viewpoint—is generally accepted as official policy.

Patient News

As the patient's personal physician, the doctor has an obligation to respect confidences that come to him in the performance of his duty and may not release news except with the patient's consent or those authorized to speak for him. When the press learns of the illness of private patients from other sources, the physician may cooperate with the press in answering any inquiries in the interest of accuracy and to avoid embarrassment.

When news of patients is of such a nature that it automatically falls in the public domain, physicians should feel free to release information within the framework of this code.

Patient information may be given where the nature of injuries, illness or treatment is of special interest. The report of such information shall be more in the nature of scientific information, rather than an exposé of an individual affliction.

Pre-Retirement TV and Film Series

Recognizing the current "retirement revolution" in which persons are retiring earlier and living longer, the ISMS Committee on Aging recently produced a 13-part, half hour weekly television series on pre-retirement planning entitled, "The Time Of Your Life."

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—features broadcast personality Norman Ross who interviews guest authorities on such vital topics as: financial and estate planning; meeting medical expenses; where to live in retirement; how to cope with physical and emotional problems; and constructive utilization of leisure time. Initially shown on Chicago television, the series is now available for loan on 16 mm. film to industries, businesses, and other organizations throughout the state and nation as a "ready made" course of instruction.

MEDICAL SELF-HELP TRAINING PROGRAM

The Disaster Medical Care Committee of the Illinois State Medical Society strongly endorses the training of at least one person in each family on procedures to follow in the event of a medical emergency. This would be of value not only in the event of an atomic disaster, when physicians would not be available, but also in caring for other emergencies until the help of a physician can be obtained.

For this reason the Society presented "Medical Self Help Training" as an official television course over educational Channel 11 in Chicago early in 1964 and again in 1965. Over 10,000 persons enrolled in this course. Response was so enthusiastic that films of the complete 15-part, 7½-hour series have been made available to county medical societies, industries, schools, and television stations throughout the state.

For complete information on this film course, as well as a "live" course for group study presentations, write the Public Relations Division of the state society.

ILLINOIS' REVISED VITAL RECORDS—1968

Revised forms for recording births, deaths, fetal deaths, marriages and divorces, developed by the Illinois Department of Public Health, were introduced Jan. 1, 1968. Major revisions of vital records occur approximately every 10 years to coincide with the revised recommendations of the United States Public Health Service on the content of vital records. These recommendations to the states, known as the "standard certificates," along with the international classification of diseases, are the two most important instruments for achieving the nationwide comparability and consistency that are so essential in the interpretation of vital statistics data.

A great deal of study and planning went into the 1968 Illinois revision. The topic of standard certificates appeared on the 1962 agenda of the biennial Public Health Conference on Records and Statistics, held in Washington, D. C. Since that time resource organizations, medical societies, hospitals, administrative organizations, law enforcement agencies and many other groups have been contacted for suggestions and recommendations. State and local registrars of vital statistics, statisticians, and other consultants served on study committees to develop specific recommendations to the United States Public Health Service on content and format.

Additional work was required to adopt these standard certificates to Illinois laws and practices. Valuable assistance and advice was obtained from a variety of special committees. Included were the Vital Statistics Committee of the Illinois State Medical Society and special committees of the Illinois Hospital Association, the Illinois Association of Medical Record Librarians, the Family Law Section of the Illinois State Bar Association, the Illinois Coroners Association, the Illinois Funeral Directors Association, the Illinois Association of County Clerks and Recorders, and the Administrative Office of the Illinois Courts.

The Illinois certificates of live birth and fetal death contain a section for health and statistical use only. Much of this information has not heretofore been collected. It is vital that the makers of certificates understand their importance, and understand that these items do not appear on certified copies of the certificate and will not be released by the official custodian of the certificate except upon court order.

The race and education of parents are used with other information on the certificate to evaluate the effect of socio-economic factors. Because of differences in these socio-economic factors, various groups in the population have different birth characteristics. By statistical analysis of these characteristics, the influence of social factors on fertility and infant survival can be studied and the social and health problems of these groups can be evaluated.

The number of previous deliveries, both births and fetal deaths, assists in estimating further birth rates and examining the effect of changing social and economic conditions on the number of children couples decide to have.

The dates of the mother's last live birth and last fetal death allow studies of the time interval between children. Understanding patterns of child spacing practices is necessary to interpret changes in birth rate trends. In addition, the outcome of a pregnancy following a fetal death is of interest to physicians and other medical research workers.

The weight of a fetus is closely related to its gestational age. The date of last normal menses also is used to calculate gestational age, which is useful in the study of fetal loss. The month of pregnancy in which a mother began her prenatal care and the number of prenatal visits she had are also related to the outcome of pregancy as well as to her own health. Thus, these items are important to those interested in improving health and medical services for mothers and babies.

Illegitimate births are an important social problem. The item about legitimacy helps to measure the extent of the problem so that medical and social programs can be designed to effectively assist unwed mothers.

The other items in this section are similarly useful for statistical research and for medical purposes.

Available from the Illinois Department of Public Health are special handbooks giving complete instructions on the preparation and filing of certificates of birth, death and fetal death. These handbooks consist of a Hospital Handbook on Birth and Fetal Death Registration; a Funeral Directors Handbook on Death and Fetal Death Registration; and a Physicians Handbook on Medical Certification: Death, Fetal Death, Birth. A Manual for Coroners was scheduled to be revised to incorporate certain new instructions during 1968.

Woman's Auxiliary To The Illinois State Medical Society

If 'life begins at 40', then the Woman's Auxiliary to the Illinois State Medical Society is starting a new phase of its existence as we start our 41st year. On our membership cards are these words "Let the helping hands of the doctor's wife reflect and enrich his dedicated service" and this is what we ask to be allowed to do. We hope that every doctor will encourage his wife to be an interested member. Paul R. Whitener, M.D., wrote in *Missouri Medicine,* "The modern doctor is often too busy to take an active role in the numerous voluntary health organizations, to get acquainted with the local newspaper editor or radio-TV manager, or to establish a personal contact with his own legislators and political leaders. Such a doctor may, however, have a wife who would be more than glad to at least try some of these community activities."

Community Health does concern us whether we live in a large city, a small town or a rural area—and we can do something about it. With the "Accent on Youth" there are prepared package programs and directions for presentation in these categories. 1. Teenage venereal disease. 2. Alcoholism 3. LSD and other drug abuses 4. Sex education 5. Preventing the smoking habit. We can work with other groups in health career clubs, health career workshops for student and councilors, loan and scholarship programs, to stimulate young people to be interested in and well qualified for health career opportunities.

Auxiliaries can help in the blood donor program. There is a new emphasis in the Home Centered Health Care. Find out how your auxiliary can promote such services and help in keeping medical costs down and prevent over taxing hospital services. Safety projects are recommended for both urban and rural areas, as well as Mental Health programs. Keep up the fund raising for the American Medical Association Education and Research Foundation and Benevolence.

Legislation is of prime importance this year. Let's be sure that the doctor's wife is well informed on what is at stake and able to work for what we believe in—the freedom of medicine. Every doctor's wife should not only register and vote but join IMPAC and AMPAC.

International Health programs have a great appeal and give us an opportunity to have a part in the endeavors of those who carry on these marvelous achievements.

Each county president has received a Membership Orientation Manual which, if used, will be most helpful in making membership more meaningful! Then, let's put our best foot forward by keeping informed and able to answer adverse criticism—by learning to listen and answer intelligently not emotionally.

Mrs. Alden Rarick
President

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   Mrs. Jan J. Kukral, 860 N. Lake Shore Dr., Chicago 60611
4. Henry, Knox, Mercer, Peoria, Rock Island, Warren
   Mrs. Richard Icenogle, Box 188, Roseville 61473
5. Logan, McLean, Sangamon, Tazewell
   Mrs. J. L. Bailen, 903 S. Mercer Ave., Bloomington 61701
6. Adams, Madison, Morgan
   Mrs. Maurice Woll, 159 S. 9th St. East Alton 62024
7. Christian, Effingham, Macon, Marion-Clinton
   Mrs. H. E. Schoonover, Route No. 4 Salem 62801
8. Champaign, C o l e s-Cumberland, Crawford, Vermilion
   Mrs. E. E. McDonnell, 1126 Wilkin Rd. Danville 61832
9. Jefferson-Hamilton
   Mrs. Edward C. Wood, 1907 Broadway, Mt. Vernon 62864
10. St. Clair, St. Clair-Belleville Branch
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11. DuPage, Kankakee, Will-Grundy
    Mrs. Richard Bowman, 600 Valley Road Itasca 60143

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427 S. Main St., Sycamore 60178

Safety ..... Mrs. Arthur Smith
206 Country Club Lane, Belleville 62223

Urban Health ..... Mrs. Franklin D. Yoder
2 Lantern Lane, Springfield 62704

WASAMA ..... Mrs. John W. Koenig
2518 Oakwood Dr., Olympia Fields 60461

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

Illinois Medical Assistants Association

The Illinois Medical Assistants Association is just what the name implies—an Association of Medical Assistants throughout the State of Illinois who have become an educational organization with objectives as follows: (a) To bring into one association all medical assistant organizations of the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical assistants societies are organized; (c) to assist the physicians in improving medical public relations; (d) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (e) to meet from time to time to secure interchange of ideas.

The medical assistant associations are educational groups—not social. *We are not a union and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.*

Now the qualified medical assistant has the opportunity to pass a special board examination and thus become a "Certified Medical Assistant." This will affect directly or indirectly every physician's office. Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination write to American Association of Medical Assistants, 510 N. Dearborn St., Chicago 60610.

Local programs in the component societies of IMAA are geared to the needs of that particular area. Obviously the strictly specialist areas would have entirely different problems and educational needs than the area of the general practitioner where the office is staffed by one or two medical assistants. Hence the educational programs in your area would be decided by your own Medical Assistants and supervised by the doctors in your own county society.

We need you, Doctor, to encourage your medical assistants to join our association. But also you could help us by assisting us in selecting the proper educational programs which in the long run would be of most benefit to you. That is our whole purpose, to become better medical assistants so we can help you to help your patients.

Illinois Association Of The Professions

The Illinois Association of the Professions is a nonprofit corporation, incorporated under the laws of Illinois on Feb. 6, 1964. Several other states such as Michigan, New York and North Carolina have already organized associations of professions with the same basic structure and purpose and an American Association of the Professions has been incorporated.

The IAP was created to provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare. This should strengthen the traditional rights, privileges and responsibilities of each profession. At the same time, it should also provide more effectively to the people adequate professional services based on skill and integrity.

The close relationships between members of the professions place them in a better position to be "molders of public policy." The IAP will devise ways and means of better utilizing the professional knowledge and skills of its members for the benefit of society and attempt to create the kind of relations between the professions which will most effectively accomplish this objective.

IAP is *not* a political organization. It is nonpartisan. But it serves its members as one practical medium of communication between the professions and legislative bodies.

IAP supplements efforts, programs and services of the individual state professional societies. The professional societies must function for the profession each represents.

The IAP benefits the individual member by helping him protect and perpetuate the individual privileges and responsibilities of the professional person. It serves as a medium of communication between the professions, devoting its activities to professional relations, public relations, legislation, education, and business services.

Through the cooperation of the professions in Illinois, who are members of the IAP, legislation in the name of HB 2432 was enacted in the 75th General Assembly and approved by Governor Otto Kerner. This legislation creates a "Division of Professional Supervision" in the Department of Registration and Education.

Eight state professional societies are Charter Members of the IAP.

Illinois Council of The American Institute of Architects.

Illinois State Dental Society.

Illinois Society of Certified Public Accountants.

Illinois Society of Professional Engineers.

Illinois State Medical Society.

Illinois Pharmaceutical Association.

Illinois State Veterinary Medical Association.

Illinois State Bar Association.

Admission of other professional societies to membership is provided for in the IAP bylaws.

The IAP is governed by a board of directors. On that board *recognition,* rather than *control,* is accorded those professions having larger numbers of individual members. IAP bylaws provide that the board of directors of each state organization shall designate two of its members, who are also members of IAP, to serve as directors. In addition to those thus provided, Directors are also elected from the general membership at the IAP Annual Meeting.

Annual dues for an individual member in IAP is $10. Annual dues for a professional society organization is $100. Applications and checks are accepted by the executive secretary of state professional associations for processing.

IAP is a "horizontal" type of organization established to answer some of the professional's problems just as other segments of society are organized. Labor, for example, has the AFL-CIO—cutting across all trades on an industry-wide basis. State and national Chambers of Commerce were created for business and the American Federation of Farm Bureaus, one of the greatest forces in our nation, is the voice of farming.

The Illinois Veterinary Medical and Medical professions have launched a joint project to establish 70 package disaster hospitals throughout the state. These hospitals are strategically located and provide all residents with readily available 200 bed units. The hospitals can be functional within two hours following a disaster. Several training areas have been established at Springfield, Elmhurst and Chicago to provide veterinarians and physicians to service these hospitals. This unique program and the first for the U.S. is under the direction of Dr. Max Klinghoffer, Elmhurst Community Hospital, Chairman of Civil Defense for the Association and Dr. Dan Parmer, Richton Park, representing the Veterinary Medical Profession.

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive, and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 58 senatorial districts and 59 representative districts. Each senate district elects one senator; each representative district elects three representatives. Thus, the Senate has 58 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms. Under normal procedure, Senators in the districts having even numbers are elected in Presidential election years; those in districts with odd numbers are chosen at elections in the intervening even-numbered years. However, recent requirements for reapportionment have created changes in this pattern.

The General Assembly normally meets in the first six months of each odd-numbered year, although it may be called into special session by the Governor. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, propose and submit amendments to the State Constitution, and to act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the Lieutenant Governor. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, and Secretary of State, Auditor of Public Accounts, Treasurer, and Superintendent of Public Instruction, and Attorney General. All of these officials are elected for four-year terms. The Treasurer is the only elected state official who cannot succeed himself.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the right to introduce bills or resolutions. After the introduction of the bill, it is referred to the appropriate committee. If the committee recommends the bill favorably, it is read a first time, usually by title, before the house, in which it was introduced. A second reading must be held on a separate legislative day when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he can either sign it or file it with the Secretary of State without his signature. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Two-thirds of the members elected to the House can override the veto. He can also veto specific items of an appropriations bill.

Appropriation Bills

"Bills making appropriations of money out of the treasury shall specify the objects and purposes for which the same are made, and if the Governor shall not approve any one or more of the items or sections contained in any bill, but shall approve the residue thereof, it shall become a law as to the residue in like manner as if he had signed it. The Governor shall then return the bill with any objections to the items or sections of the same not approved by him to the House in which the bill shall have originated, which House shall enter the objections at large upon its journal and proceed to reconsider so much of said bill as is not approved by the Governor. Any item or section of said bill not approved by the Governor shall be passed by two-thirds of the members elected to each of the two Houses of the General Assembly, it shall become part of said law, notwithstanding the objections of the Governor. Any bill which shall not be returned by the Governor within ten days, Sundays excepted after it shall have been presented to him, shall become a law in like manner as if he had signed it, unless the General Assembly shall, by their adjournment, prevent its return, in which case it shall be filed with his objections in the office of the Secretary of State within ten days after such adjournment or become a law." (Article V, Section 16, Illinois Constitution)

NOTE

A Legislative Directory containing the names and addresses of all members of the 75th Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield, 62701.

STATE OFFICERS

Governor, SAMUEL H. SHAPIRO, Dem., Kankakee
Lieutenant Governor, VACANT
Secretary of State, PAUL POWELL, Dem., Vienna
Auditor of Public Accounts, MICHAEL J. HOWLETT, Dem., Chicago
State Treasurer, ADLAI E. STEVENSON, III, Dem., Chicago
Attorney General, WILLIAM G. CLARK, Dem., Chicago
Superintendent of Public Instruction, RAY PAGE, Rep., Springfield

DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield 62706

Harold M. Visotsky, M.D., Director
Mortimer Brown, Ph.D., Assistant to the Director
Mrs. Anne M. Konar, Executive Assistant to the Director
Mrs. Christine Dahlberg, Secretary to the Director
Leo Fitzgerald, Administrative Assistant
John B. Acheson, Special Assistant
Robert Lanier, Special Assistant
Margaret Schilling, Special Assistant
William Lewis, Jr., Special Assistant (Public Information)
Robert Dahl, Public Information Officer
Jerome Goldberg, Special Counsel
Philip Arben, D.C.S., Management Consultant
Mrs. Jo Buchanan, Office Manager, Chicago General Office

Division of Planning and Evaluation Services

Leo Levy, Ph.D., Division Director
Ralph W. Collins, Assistant Division Director (Metropolitan)
Samuel Weingarten, Ph.D., Assistant Division Director (Downstate)
Allen Herzog, Supervisor, Management Information Section
Mrs. Elizabeth Slotkin, Chief, Program Analysis and Evaluative Research
Joseph R. Godwin, Ph.D., Behavioral Scientist
Louis Rowitz, Research Sociologist
Miss Helen Lambrakis, Urban Planning Specialist
Mrs. Mary Grossberg, Communications Specialist

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Lawrence Bussard, Assistant Division Director (Administration)
Charles Jubenville, Ed.D., Assistant Division Director (Extra-Mural Programs)
Richard Scheerenberger, Ph.D., Assistant Division Director (Prog. Coordination)
Ralph Wagner, Assistant Project Coordinator
Christian Simonson, Administrator, Waiting List
Donald Kimbrell, Ph.D., Consultant, Day Program —Mentally Retarded
Thomas Villiger, Administrator, Individual Care Grants
Mrs. Ruth Bartle, Private Care Consultant

Institutions

A. L. Bowen Children's Center, A. J. Shafter, Ph.D., Superintendent
Dixon State School, David Edelson, Superintendent
William W. Fox Children's Center, Thomas P. Crane, M.D., Superintendent
Lincoln State School, Louis Belinson, M.D., Superintendent
Warren G. Murray Children's Center, William B. Bradley, Acting Superintendent

Division of Professional Services

Abel G. Ossorio, Ph.D., Division Director
Myrna B. Kassel, Ph.D., Assistant Division Director (Training)
Mrs. Annette Calloway, Chief, Psychiatric Social Services
Paul F. Cole, R.Ph., Supervising Pharmacist
Ira D. Cravens, Chief, Veterans Services
A. A. Kaluzny, M.D., Medical Services
A. A. Kaluzny, M.D., Chief, Tuberculosis Control
C. P. Macaluso, Chief, Clinical Laboratories
Mrs. Louise A. Meyer, R.N., Assistant Chief, Nursing Services
Abel G. Ossorio, Ph.D., Chief, Psychology Services
Miss Jane Phillips, Chief, Volunteer Services
Rudyard Propst, Chief, Rehabilitation Services
Paul A. Rittmanic, Ph.D., Chief, Speech and Hearing Services
Lyman Samo, Chief, Special Education Services
Miss Ruth Vanderhorst, R.N., Assistant Chief, Nursing Services

Division of Comprehensive Mental Health Services, Hospitals and Clinics

Thomas A. Tourlentes, M.D., Acting Division Director

Zones and Institutions

ROCKFORD: Ronald W. Johnson, M.D., Zone Director, H. Douglas Singer Zone Center, 4402 N. Main St., Rockford 61103

METROZONE: Hyman C. Pomp, Ph.D., Acting Director, Chicago State Hospital, 6500 W. Irving Park Rd., Chicago 60634

North Central Chicago Sub-Zone: Hyman C. Pomp, Ph.D., Director, Read-Chicago State Mental Health Centers, 6500 W. Irving Park Rd., Chicago 60634

CHARLES F. READ ZONE CENTER: Hyman C. Pomp, Ph.D., Superintendent, 4200 N. Oak Park Ave., Chicago 60634

CHICAGO STATE HOSPITAL: Hyman C. Pomp, Ph.D., Superintendent, 6500 W. Irving Park Rd., Chicago 60634

MENTAL HEALTH CENTER: Hyman C. Pomp, Ph.D., Superintendent, 2449 W. Washington Blvd., Chicago 60612

Northwest Chicago Sub-Zone: Arthur Woloshin, M.D., Director, Madden-Elgin Mental Health Centers, 1200 S. First Ave., Hines 60141

JOHN J. MADDEN ZONE CENTER: (vacant), Superintendent, 1200 S. First Ave., Hines 60141

ELGIN STATE HOSPITAL: Ernest Klein, M.D., Superintendent, Elgin 60120

South Chicago Sub-Zone: Bernard Rubin, M.D., Director, Tinley Park-Manteno Mental Health Centers, Tinley Park 60477

MANTENO STATE HOSPITAL: H. C. Piepenbrink, Superintendent, Manteno 60950
TINLEY PARK MENTAL HEALTH CENTER: John F. Lowney, Jr., M.D., Superintendent, Tinley Park 60477

PEORIA: Thomas T. Tourlentes, M.D., Zone Director, George A. Zeller Zone Center, Peoria 61614 (address mail to Galesburg State Research Hospital, Galesburg 61401)
GEORGE A. ZELLAR ZONE CENTER: James Ward, M.D., Superintendent, 5407 N. University, Peoria 61614
EAST MOLINE STATE HOSPITAL: Konstantin Dimitri, M.D., Superintendent, East Moline 61244
GALESBURG STATE RESEARCH HOSPITAL: Thomas T. Tourlentes, M.D., Superintendent, Galesburg 61401
PEORIA STATE HOSPITAL: Henry D. Staras, M.D., Superintendent, Peoria 61607

SPRINGFIELD: Charles E. Beck, M.D., Zone Director, Andrew McFarland Zone Center, Springfield 62707
ANDREW McFARLAND ZONE CENTER: (vacant), Superintendent, I-55 & Toronto Rd., Springfield 62707
JACKSONVILLE STATE HOSPITAL: Steve Pratt, Ph.D., Superintendent, Jacksonville 62526

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ADOLF MEYER ZONE CENTER (Adults): Lewis Kurke, M.D., Acting Superintendent, East Mound Rd., Decatur 62526
HERMAN M. ADLER ZONE CENTER (Children): Robert Harden, Acting Superintendent, 2204 Griffith Dr., Champaign 61820

EAST ST. LOUIS: Ivan Pavkovic, M.D., Zone Director, Anna 62906 (Zone Office: 310 N. 10th, East St. Louis 62201)

CARBONDALE: Robert C. Steck, M.D., Zone Director, Anna 62906
ANNA STATE HOSPITAL: Robert C. Steck, M.D., Superintendent, Anna 62906
ILLINOIS SECURITY HOSPITAL: Bert Rednour, Superintendent, Chester 62233

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Charles R. Meeker, Chief
B. W. Tucker, Chief, Mental Health Education
Joseph B. Lehmann, Consultant, Community Mental Health Clinics
Muriel Rietz, Chief, Interstate Services

Alcoholism Programs

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William N. Becker, Jr., Assistant Chief
Howard W. Wolff, Administrator Warren Clinic
Peoria State Hospital, Intensive Treatment Unit

Medical Center Complex

Lester H. Rudy, M.D., Director, Medical Center Complex

Institute for Juvenile Research

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Noel Jenkin, Ph.D., Director of Research
Downtown Research Branch
William Healy School
Theodore E. TePas, M.D., Medical Director

Illinois State Pediatric Institute

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Jeanette Schulz, M.D., Acting Director of Research

Illinois State Psychiatric Institute

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Field Division, Mental Health, Department of Personnel

Don O'Donnell, Division Director
David Jenkins, Assistant Division Director (Programs)

Division of General Services

E. F. Merten, Division Director
Joseph L. McGrath, Deputy Director, Physical Plant Services
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Reimbursement Services
Gerald Hurd, Deputy Director, Budgetary Services

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Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health; Alex Elson, Chairman, Board of Mental Health Commissioners; Herbert J. Grossman, M.D., Director, Illinois State Pediatric Institute; Lester H. Rudy, M.D., Director, Medical Center Complex

3. Board of Reimbursement Appeals

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Melvin Sabshin, M.D., Chicago
Jackson Smith, M.D., Hines
Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health

Advisory Committees—Administrative Appointment

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Paul B. Musgrove, Peoria, Secretary
J. Milton Guy, Chicago
A. A. Kaluzny, M.D., Chicago
George E. Moredock, Jr., Chicago
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Robert J. Dancey, M.D., Mt. Vernon
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Clifton Hall, M.D., Springfield
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M. R. Lichtenstine, M.D., Chicago
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Robert Sykes, M.D., Chicago
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George C. Turner, M.D., Chicago
Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health; A. A. Kaluzny, M.D., Chief, Tuberculosis Control, Department of Mental Health

3. Advisory Committee on Grants to Local Communities for Mental Health Services

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Rt. Rev. Msgr. William J. Cassin, Springfield
O. M. Chute, Ed.D., Evanston
Robert S. Daniels, M.D., Chicago
Robert L. Farwell, Chicago
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Donaldson F. Rawlings, M.D., Springfield
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Mrs. H. Langdon Robinson, Springfield
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4. Advisory Council—Public Law 88-164, Construction Grants

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Senator Charles Chew, Chicago
Senator Clifford Latherow, Carthage
Senator Arthur R. Swanson, Chicago
Representative Norbert G. Springer, Chester
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Joseph S. Skom, M.D., Chicago
Alfred Slicer, Springfield
Harold O. Swank, Springfield
Judge Kenneth R. Wendt, Chicago
Franklin D. Yoder, M.D., Springfield
Nicholas Zagone, Chicago
John B. Acheson, Chicago, Executive Secretary

DEPARTMENT OF PUBLIC HEALTH

503 State Office Bldg., Springfield 62706
Franklin D. Yoder M.D., M.P.H., Director
E. L. Wittenborn M.P.H., Assistant to the Director

Division of General Administration

E. L. Wittenborn, M.P.H., Chief

Bureaus of:

Administration—E. L. Wittenborn, M.P.H., Chief
Accounting and Finance—Ira Shipley, Acting Chief
Electronic Data Processing—Isabelle Crawford, Chief
Health Education—Lynford L. Keyes, M.P.H., Chief
Consultant Section—Gordon Rude, M.P.H., Jerry Sappington, M.S.P.H.
Injury Control Section—James Diekroeger, M.S.P.H., Associate Chief
Nursing—Pearl H. Ahrenkiel, R.N., B.S., Chief; Grace Musselman, R.N., M.P.H., Assistant Chief; Alice Starr, R.N., M.A., Consultant Nurse
Statistics—E. L. Wittenborn, M.P.H., Acting Chief; Don D. Vance, M.A., Administrative Officer; Leo A. Ozier, Deputy State Registrar; Clyde A. Bridger, M.S., Chief Statistician

Chicago Offices:

Benn J. Leland, M.S., Division of Sanitary Engineering, 1919, W. Taylor St., Chicago 60612

Division of Dental Health

Carl L. Sebelius, D.D.S., M.P.H., Chief
John D. Thorpe, D.D.S., M.P.H., Assistant Chief

Bureaus of:

Research and Special Studies, John D. Thorpe, D.D.S., M.P.H., Chief
Continuing Education—Robert L. Pokorney, D.D.S., M.P.H.

Division of Foods and Drugs

Roy W. Upham, D.V.M., Chief
James V. Burke, Assistant Chief
William A. Grills, M.P.H., Food Sanitation Consultant

Division of Health Care Facilities And Chronic Illnesses

R. F. Sondag, M.D., M.P.H., Chief

Bureaus of:

CHRONIC ILLNESS
William J. Cassel, Jr., M.D., M.P.H., Chief
Edith Heide, R.N., B.S., Consultant Nurse, Aging and Chronic Illness

CHRONIC RENAL DISEASES
Ruth Shriner, A.S.C.W., Social Service Consultant
Ted Moore, B.S., Public Health Advisor, USPHS
Rheumatic Fever Control Program—William J. Cassel, Jr., M.D., M.P.H., Chief

HEALTH FACILITIES
Harold E. Josehart, M.S.H.A., Chief
Robert R. Cunningham, B.S., Special Assistant

Licensure and Certification Section
Joseph I. Hutchinson, M.S.H.A., Coordinator
Frank Moore, A.B., Standards Representative, Long-term Care Facilities
Agnes Burns, R.N., Nurse Consultant Supervisor, Hospitals
Donald G. Higgins, Medicare & Licensure, Medicare Program Representative

Planning and Construction Section
Aden H. Clump, M.A., Program Executive

Rehabilitation Section
Albert R. Siegel, M.D., Physiatrist, Consultant in Physical Medicine and Rehabilitation (Part-time)
Janet Chermak, O.T.R., Supervisor of Rehabilitation Education Service

Consultative and Analytical Service
Maternity Statistics—Alice S. Flesch, R.N.
Reimbursable Costs—Robert J. McMahon
Packaged Disaster Hospital Program—Earl Murphy, B.A.

Division of Laboratories

Richard A. Morrissey, M.P.H., Chief
John Francis Clark, Business Administrator

Bureaus of:
Biologic Products—John Neal, Ph.C., Chief
Diagnostic Services—Mary Louise Brown, M.S., Chief
Laboratory Evaluation—Robert G. Martinek, Pharm., D., Acting Chief
Sanitary Bacteriology—Robert M. Scott, M.S., Chief
Toxicology—Frank F. Fiorese, Ph.D., Chief
Virus Diseases and Research—Richard Morrissey, M.P.H., Chief

Laboratories:
Springfield Diagnostic Laboratory
Kirby Henkes
134 N. Ninth St., Springfield 62706
Springfield Sanitary Bacteriology Laboratory
Arnold Westerhold, B.S.,
6th Floor Capitol Bldg., Springfield 62706
Carbondale Laboratory
Nathan Nagle, M.P.H.
Oakland & Chautauqua Sts., Carbondale 62901
Champaign Laboratory
Elizabeth Frazee, B.A.
505 S. Fifth St., Champaign 61820
Chicago Laboratory
Richard A. Morrissey, M.P.H.
1800 W. Fillmore, Chicago 60612
East St. Louis Laboratory
Charles S. Puntney, A.B.
414 Missouri Ave., East St. Louis 62201
Rock Island Laboratory
Bettie Anne Muffley, B.S.
121 Fourth Ave., Rock Island 61201

Division of Milk Control

Enos G. Huffer, B.S., Chief
Paul N. Hanger, B.S., Supervisor of Grade A Production
Grover C. Papp, Supervisor, Common Carriers of Grade A Products
Roy Fairbanks, Supervisor, I.S.M. Program

Division of Preventive Medicine

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Norman J. Rose, M.D., M.P.H., Assistant Chief

Bureaus of Epidemiology
Norman J. Rose, M.D., M.P.H., Chief
Philip R. Wactor, Jr., B.S., Public Health Advisor, USPHS, Venereal Disease Control
Section on Veterinary Public Health—Paul R. Schnurrenberger, D.V.M., M.P.H., Chief Public Health Veterinarian
Russell J. Martin, D.V.M., M.P.H., Regional Public Health Veterinarian
Illinois Immunization Program—Richard H. Shirley, B.S., Project Coordinator, USPHS
Trafic Safety Section—Norman J. Rose, M.D., M.P.H.

Hazardous Substances and Poison Control
Norman J. Rose, M.D., M.P.H., Chief
James J. Boland, B.A., Pesticide Project Coordinator, USPHS

Maternal and Child Health
James P. Paulissen, M.D., Ph.D., Chief
Ethel G. Chapman, R.N., B.S., Consultant Nurse in Maternal and Child Health
Vida B. Sloan, R.N., B.S., Consultant Nurse in Maternal and Child Health
Iva Aukes, M.S.W., Social Service Consultant
Maria Baisier, D.D.S., M.P.H., Statistical Epidemiologist
Migrant Health Section—J. Kent Capps, B.S., Coordinator
Heritable Metabolic Diseases Program—William J. Dewey, M.S., Chief

School Health
D. F. Rawlings, M.D., M.P.H., Chief
Caroline Austin, M.Ed., Vision Conservation Coordinator
Phil B. Shattuck, M.A., Hearing Conservation Coordinator
Harry C. Bostick, M.P.H., Coordinator-School Health Services
Helen H. Natwick, R.N., M.P.H., Consultant Nurse
Mary Zeldes, M.D., Consultant in Pediatrics

Division of Sanitary Engineering

Clarence W. Klassen, B.S., Chief
Verdun Randolph, M.P.H., Assistant Chief
R. S. Nelle, B.S., Water Resource Engineer

Bureaus of:
Air Polution Control—Robert R. French, Ch.E., Chief
General Sanitation—O. S. Hallden, B.S., Chief
Public Water Supplies—William H. Honsa, B.S., Acting Chief
Radiological Health—Verdun Randolph, M.P.H., Acting Chief
Stream Pollution—D. B. Morton, B.S., Chief

Chicago Office—Sanitary Water Board
Benn J. Leland, M.S., Engineer-in-Charge

Division of Tuberculosis Control

Clifton Hall, M.D., M.P.H., Chief
Alvin B. Grant, B.S., Public Health Advisor, USPHS
Chicago State Tuberculosis Sanitarium—Herbert Neuhaus, M.D., Medical Director and Superintendent
Mt. Vernon State Tuberculosis Sanitarium—Robert J. Dancey, M.D., Medical Director and Superintendent

Division of Local Health Services

Charles F. Sutton, M.D., M.P.H., Chief
Claire E. Healey, M.D., M.P.H., Assistant Chief
E. E. Diddams, M.S.P.H., Executive Assistant

Sections on:
Emergency Health and Civil Defense
Earl Murphy, B.A., Civil Defense Coordinator, USPHS
Mary O'Donnell, R.N., Medical Self-Help Consultant

Arthur Jackson, B.S., Public Health Advisor, USPHS

John Sturgeon, Emergency Health Representative

Community Health Services Promotion—Harold K. Fuller, M.P.H., Head

Illinois State Wide Public Health Committee
Harold K. Fuller, M.P.H., Executive Secretary

Regional Offices

Northeastern Region (I)—William H. Keeler, M.D., M.P.H., 48 W. Galena Blvd., Aurora 60504. Counties of Boone, Kane, Kankakee, LaSalle and consultation to full-time health departments of Cook, DeKalb, DuPage, Grundy, Kendall, Lake, McHenry, Will, and Winnebago Counties. Urban: Berwyn Township Public Health District, Evanston-North Shore, Rockford, Oak Park, Hygienic Institute of LaSalle-Oglesby-Peru, Skokie, and Stickney Township Public Health District.

East Central Region (II)—Russell L. Bryant, B.S. (Acting), 301 W. Birch St., Champaign 61820. Counties of Champaign, Clark, Coles, Cumberland, Edgar, Ford, Iroquois, and Moultrie and consultation to full-time health departments of DeWitt-Piatt, Douglas, Effingham, Livingston McLean, Shelby, Vermilion. URBAN—Champaign-Urbana Public Health District.

Northwestern Region (III)—Arthur E. Sulek, M.D., M.P.H., 121 Fourth Ave., Rock Island 61201. Counties of Bureau, Hancock, Henderson, Knox, Marshall, McDonough, Putnam, Stark, Tazewell, Warren, and Woodford and consultation to full-time health departments: Counties—Carroll, Henry, Jo Daviess, Lee, Mercer, Ogle, Peoria, Rock Island, Stephenson, and Whiteside, City: Peoria.

West Central Region (IV)—W. M. Talbert, M.D., M.S.P.H., 1124 S. Fifth St., Springfield 62706. Counties of Brown, Cass, Greene, Logan, Macoupin, Mason, Sangamon, Schuyler, and Scott and consultation to full-time health departments: Counties—Adams, Calhoun, Christian, Fulton, Jersey, Macon, Menard, Mongomery, Morgan, and Pike.

South Region (V)—Elvin L. Sederlin, M.D., P.O. Box 722, Carbondale 62901. Counties of Hamilton and Perry and consultation to full-time health departments: Counties—Egyptian, (Gallatin-Saline-White,) Franklin-Williamson, Jackson, Quadri-County, (Hardin-Johnson-Massac-Pope), Randolph, (Tri-County, Alexander-Pulaski-Union).

Region (VI)—E. E. Diddams, M.S.P.H. (Acting) 435 Missouri Ave., Room 410, East St. Louis 62201. Counties of Clinton, Crawford, Edwards, Fayette, Jasper, Jefferson, Madison, Marion, Richland, St. Clair, Wabash, Washington, and Wayne and consultation to full-time health departments: Counties—Bond, Clay, Lawrence, and Monroe: Urban—East Side Health District (Canteen-Centreville-East St. Louis-Stites Township).

County and Multiple-County Health Departments

Adams County, Wayne Messick, M.P.H., 333 N. 6th, Quincy 62301

Bond County, Mrs. Carole Bone, R.N., Acting Administrator, 100 N. Locust, Greenville 62246

Calhoun County, Mrs. Margaret Hillen, R.N., Acting Administrator, Hardin 62047

Carroll County, Mrs. Joyce Daehler, R.N., Acting Administrator, Mt. Carroll 61053

Christian County, Clara J. Beaty, R.N., Acting Administrator, 106 E. Main St., Taylorville 62568

Clay County, E. D. Foss, M.D., 104½ W. Second St., Flora 62839

Cook County, John B. Hall, M.D., M.P.H., Director, 1425 S. Racine Ave., Chicago 60608

North District, 1755 Oakton St., Des Plaines 60018

South District, 51 E. 154 St., Harvey 60426

Southwest District, 5410 W. 95th St., Oak Lawn 60453

West District, 1907-09 Rice St., Melrose Park 60160

DeKalb County, Mrs. Audre Anderson, R.N., B.S., Acting Administrator 1731 Sycamore Rd., DeKalb 60115

DeWitt-Piatt Bi-County, Lelia V. Hyde, R.N., Acting Director, 122 E. Main St., Clinton 61727

Piatt County, Courthouse, Monticello 61856

Douglas County, Mary Lou Pflum, R.N., B.S., Acting Administrator, P.O. Box 382, Tuscola 61953

DuPage County, Charles A. Lang, M.D., M.P.H., Health Officer, 222 E. Willow Ave., Wheaton 60187

Effingham County, Peter C. Supan, M.D., M.P.H., Health Officer, 112 E. Section Ave., Effingham 62401

Egyptian (Gallatin-Saline-White Counties) Allen Kelly, B.S., Acting Administrator, 1333 Locust St., Eldorado 62930

White County, 208 N. Church, Carmi 62821

Gallatin County, Courthouse, Shawneetown 62984

Franklin-Williamson Bi-County, David P. Richerson, M.D., M.P.H., Health Officer, 217 E. Broadway, Johnston City 62951

Franklin County, P.O. Box 461, 226 N. Main, Benton 62812

Fulton County, Wilma Sturgeon, R.N., Acting Health Officer, 31 S. Main St., Canton 61520

Grundy County, Mrs. Mary C. Reed, R.N., Acting Administrator, Court House, Morris 60450

Henry County, Grace Van Vooren, R.N., Acting Administrator, Court House Annex, Cambridge 61238

Jackson County, Mrs. Kathleen B. Vahn, R.N., M.S., Acting Health Officer, 1015½ Chestnut St., Murphysboro 62966

Jersey County, Mrs. Nola Kramer, R.N., Acting Administrator, Court House, P.O. Box 69, Jerseyville 62052

Jo Daviess County, Alice J. Grimm, R.N., Acting Administrator, 311 S. Main St., Galena 61036

Kendall County, Mrs. Nancy J. Larson, R.N., Acting Administrator, Yorkville 60560

Lake County, John J. Ring, M.D., Acting Director, 2307 Grand Ave., Waukegan 60085
West Sub-office, 330 N. Milwaukee Ave., Libertyville 60048

Lawrence County, Maxine Jackman, R.N., Acting Director, Court House, Lawrenceville 62439

Lee County, E. S. Parmenter, M.D., Health Officer, 316 W. Third St., Dixon 61021

Livingston County, Mrs. Ann M. Lavin, R.N., Acting Administrator, Rm. 418, Bank of Pontiac Bldg., Pontiac 61764

Macon County, Leo Michl, Jr., M.S., 1085 S. Main St., Decatur 62521

McHenry County, Ward C. Duel, M.P.H., Administrator, 209 N. Benton St., Woodstock 60098

McLean County, R. E. Baxter, M.D., Acting Medical Director, 401 W. Virginia Ave., Normal 61761

Menard County, Mrs. Marjorie White, R.N., Acting Administrator, Court House, Petersburg 62675

Mercer County, Mrs. Meba V. Keeseen, R.N., Acting Administrator, Court House, Aledo 61231

Monroe County, Mrs. Edith Trost, R.N., Acting Administrator, Court House, Waterloo 62298

Montgomery County, Willis L. Whitlock, Acting Health Officer, Box 149, Hillsboro 62049

Morgan County, William D. Meyer, B.S., Administrator, 234½ W. State St., Jacksonville 62650

Ogle County, Sandra L. Greenfield, R.N., Acting Administrator, 106 S. Fifth St., Oregon 61061

Peoria County, Fred Long, M.D., M.P.H., Director of Health, 2114 N. Sheridan Rd., Peoria 61604

Pike County, Mrs. Martha Lowry, R.N., Acting Administrator, Court House, Pittsfield 62362

Quadri-County (Hardin-Johnson-Massac-Pope Counties), John J. Cipolla, Acting Health Officer, M.S.P.H., Box 437, Golconda 62938
Massac County, Courthouse, P.O. Box 133, Metropolis 62960
Johnson County, Vienna 62995
Hardin County, Gross Bldg., Elizabethtown 62931

Randolph County, Mrs. Marilynn Murphy, R.N., B.A., Acting Administrator, 110 W. Jackson St., Sparta 62286

Rock Island County, Court House, Rock Island 61201

Shelby County, Peter C. Supan, M.D., M.P.H., Health Officer, 123 N. Broadway, Shelbyville 62565

Stephenson County, Mrs. Fern M. Brown, R.N., Acting Administrator, 12 N. Galena Ave., Freeport 61032

Tri-County (Alexander-Pulaski-Union Counties), Margaret Cotton, R.N., Health Officer, 1115 Cedar St., Cairo 62914

Vermilion County, Mrs. Helen Armantrout, R.N., B.S., Acting Administrator, 808 N. Logan, Danville 61833

Whiteside County, Mrs. Romona Stene, R.N., Acting Administrator, 201 W. First St., Rock Falls, 61071

Will County, Herbert S. Miller, M.D., M.P.H., Health Officer, 21 E. Van Buren St., Joliet 60431

Winnebago County, Robert H. Anderson, Acting Health Officer, 425 W. State St., Rockford 61101

Urban Health Departments

Berwyn Health Department, Henry S. Swiontek, M.D., Health Officer, 6600 W. 26th St., Berwyn, 60402

Champaign—Urbana Public Health District, L. L. Fatherree, M.D., M.P.H., Public Health Director, 505 S. Fifth St., Champaign 61820

Chicago Board of Health, Morgan J. O'Connell, M.D., M.P.H., Acting Commissioner of Health, Chicago Civic Center, Chicago 60602

East Side Health District (Canteen-Centerville-East St. Louis-Sites Townships), John J. Gregowicz, M.D., Acting Public Health Director, 638 N. 20th St., East St. Louis 62205

Evanston-North Shore Health Department, Allan A. Filek, M.D., M.S.P.H., Public Health Director, Box 870, Evanston 60204

Hygienic Institute (LaSalle-Oglesby-Peru), Arlington Ailes, M.D., M.P.H., Director, LaSalle 61301

Oak Park Department of Public Health, Herbert Ratner, M.D., Public Health Director, Box 31, Oak Park 60303

Peoria Department of Health, Fred Long, M.D., M.P.H., Director of Health, 2116 N. Sheridan Rd., Peoria 61604

Rockford Department of Public Health, Arlu J. Anderson, B.S., Acting Commissioner of Health, City Hall Bldg., Rockford 61104

Skokie Health Department, Domingo Leonida, M.D,. M.P.H., Director of Health, 5127 Oakton St., Skokie 60087

Stickney Township Public Health District, Gene J. Franchi, D.D.S., M.P.H., Acting Public Health Director, 5635 State Rd., Oak Lawn 60459

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Director's Office:

Room 404, New State Office Bldg., Springfield
Room 1713, 160 N. LaSalle St., Chicago
Edward T. Weaver, Director
Roman L. Haremski, Deputy Director
Richard S. Laymon, Administrative Asst. to Director
J. Keller Mack, M.D., Medical and Public Health Officer
Thomas Londrigan, Special Counsel
Don H. Schlosser, Administrator of Community Relations

Division of Administrative Services:

Matthew J. Finnell, Division Chief
Room 404, New State Office Bldg., Springfield

Division of Child Welfare:

Herschel L. Allen, Division Chief
528 S. Fifth St., Springfield

Regional and District Offices—

Rockford Region (Margaret Kennedy, Reg. Dir.), 428 Seventh St., Rockford
Ottawa District, 628 Columbus St., Ottawa
Rock Falls District, 203½ First Ave., Rock Falls
Chicago Region (Ralph Baur, Acting Reg. Dir.) 1026 S. Damen, Chicago
Aurora Region (Leland Wright, Reg. Dir.), 411 W. Galena Blvd., Aurora
Joliet District, Rm. 309, 57 W. Jefferson, Joliet
Waukegan District, 4 S. Genessee, Waukegan
Peoria Region (Francis Paule, Reg. Dir.), 608 N. E. Jefferson, Peoria
Peoria District, 414 Hamilton Blvd., Peoria
Galesburg District, 121 S. Prairie, Galesburg
Rock Island District, 211-18th St., Rock Island
Princeton District, 22 E. Marion, Princeton
Springfield Region (Wm. Sanders, Reg. Dir.), 1035 Outer Park Dr., Springfield
Quincy District, 410 N. Ninth, Quincy
Carlinville District, 494½ West Side Square, Carlinville
Jacksonville District, 602 Westgate, Jacksonville
Champaign Region (Merle Springer, Reg. Dir.), 2125 S. First St., Champaign
Bloomington District, 309 W. Market, Bloomington
Decatur District, 125 N. Franklin, Decatur
Kankakee District, 70 Meadowview Center, Kankakee
Mattoon District, 1000 Broadway, Mattoon
Carbondale Region (Paul Nelson, Reg. Dir.), 1202 W. Main, Carbondale
Harrisburg District, 10 S. Vine St., Harrisburg
East St. Louis Region (Jack Donahue, Reg. Dir.), 417 Missouri Ave., E. St. Louis
East St. Louis District, 435 Missouri Ave., East St. Louis
Olney District, 1108 S. West St., Olney
Salem District, 205 E. Locust, Salem

Division of Children's Schools:

Lee A. Iverson, Division Chief
Room 404, New State Office Bldg., Springfield

Institutions—

Illinois Braille and Sight Saving School (Jack Hartong, Supt.), Jacksonville
Illinois School for the Deaf (Kenneth Mangan, Supt.), Jacksonville
Illinois Children's Hospital-School (Paul Kavanaugh, Supt.) 1950 W. Roosevelt Rd., Chicago
Illinois Soldiers' and Sailors' Children's School, (Andrew Spelios, Supt.), Normal
Southern Illinois Children's Service Center (Paul Nelson, Supt.), Hurst

Division of Personnel Administration:

Thomas A. Nickell, Division Chief
Room 404, New State Office Bldg., Springfield

Division of Planning, Research and Statistics:

William H. Ireland, Division Chief
630 E. Adams St., Springfield

Division of Rehabilitation Services:

Charles Adams, Division Chief
Room 404, New State Office Bldg., Springfield

Institutions—

Illinois Eye and Ear Infirmary (George Geocaris, Supt.), 1855 Taylor, Chicago

Illinois Soldiers' and Sailors' Home (James A. Schapers, Supt.), Quincy.

Illinois Visually Handicapped Institute (Thomas Murphy, Supt.) 1151 S. Wood St., Chicago

Visually Handicapped Services—

Community Services for the Visually Handicapped (I. N. Miller, Supt.), Room 1700, 160 N. LaSalle St., Chicago (field offices located in each regional office—see listings under Division of Child Welfare)

Coordinator of Visually Handicapped Services (Raymond M. Dickinson), 404 New State Office Bldg., Springfield.

DEPARTMENT OF PUBLIC AID

The Illinois Department of Public Aid administers the federally aided public assistance programs: Assistance to the Aged, Blind or Disabled; Aid to Dependent Children; and Medical Assistance. In addition, the department allocates state funds to qualified governmental units for the administration of General Assistance; and in cooperation with the United States Department of Agriculture, administers the Food Stamp program and distributes federally donated foods.

Overall responsibility for the department's administrative responsibilities are delegated by the Governor to the Director of the Illinois Department of Public Aid, Springfield. The director administers the programs through the staffs of eight major divisions located in the state offices, six regional offices, and 102 county departments.

Administrative Staff

Harold O. Swank, Director

Gershom Hurwitz, Assistant to the Director

Robert L. Hyde, Chief, Division of Accounting and Data Processing
Garrett W. Keaster, Chief, Division of Administrative Services
Henry L. McCarthy, Chief, Division of Community Services
James M. Brown, Chief, Division of Downstate Operations
Henry A. Holle, M.D., Medical Director, Division of Medical Services
Robert G. Wessel, Chief, Medical Administration
Mrs. Janet P. Kahlert, Chief, Division of Program Development
Richard N. Hosteny, Chief, Division of Special Investigations
Kenneth E. Doeblin, Chief, Division of Special Services
Wayne D. Epperson, Chief, Division of Research and Statistics

Regional Offices

Region I —Peoria	Frank G. Blumb, Regional Director
Region II —Champaign	C. H. Colwell, Regional Director
Region III—Springfield	Robert A. Hamrick, Regional Director
Region IV—Belleville	Armin A. Rippelmeyer, Regional Director
Region V —Carbondale	Lawrence E. Duff, Regional Director
Region VI—Rockford	Reno L. Lenz, Regional Director

Legislative Advisory Committee on Public Assistance

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The Honorable Daniel Dougherty, Chicago
The Honorable Walter P. Hoffelder, Chicago
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The Honorable Esther Saperstein, Chicago
The Honorable Merle K. Anderson, Durand
The Honorable Corneal A. Davis, Chicago
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Medical Care Advisory Committee

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Ex-Officio members

Edward F. Lis, M.D., Director, Division of Services for Crippled Children University of Illinois, Chicago
Alfred Slicer, Director, Division of Vocational Rehabilitation, Springfield

Harold M. Visotsky, M.D., Director,
Department of Mental Health, Springfield
Edward T. Weaver, Director,
Department of Children and Family Services, Springfield
Franklin D. Yoder, M.D., M.P.H., Director,
Department of Public Health, Springfield

Department of Public Aid Representative

Henry A. Holle, M.D., Medical Director,
Division of Medical Services, Department of Public Aid, Springfield

State Medical Advisory Committee

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Rex O. McMorris, M.D., Peoria
Charles E. Baldree, M.D., Belleville
James R. Cooper, M.D., Quincy
George T. Mitchell, M.D., Marshall
Frank B. Norbury, M.D., Jacksonville
Alphonse L. Robinson, M.D., Mounds
William Scanlon, M.D., LaSalle
John H. Steinkamp, M.D., Belvidere
R. Kent Swedlund, M.D., Watseka
Louis Arp, Jr., M.D., Moline
Herbert V. Fine, M.D., Carterville
George F. Lull, M.D., Chicago
Robert C. Muehrcke, M.D., Oak Park

State Drug Advisory Committee

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Miles N. Brown, R.Ph., Mount Vernon
W. Edwin Brown, R.Ph., Quincy
Carl V. Daschka, R.Ph., Chester
H. M. F. Doden, Sr., R.Ph., Rock Island
Justin Eisele, R.Ph., East St. Louis
Louis Gdalman, R.Ph., Chicago
John T. Gulick, R.Ph., Danville
John F. Koller, R.Ph., Berwyn
Roy B. Maher, R.Ph., Springfield
Theodore R. Sherrod, R.Ph., M.D., Chicago
Harold J. Shinnick, R.Ph., Chicago
Charles P. Skaggs, R.Ph., Harrisburg.

State Dental Advisory Committee

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Ross Bradley, D.D.S., Jacksonville
John J. Byrne, D.D.S., Chicago
John C. Clarno, D.D.S., Peoria
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Lewis K. Holzman, D.D.S., Chicago
Eugene J. Jaffe, D.D.S., Chicago
D. J. McCullough, D.D.S., Mt. Vernon
H. B. Riley, D.D.S., Newton
William J. Rogers, D.D.S., Chicago
Carl L. Sebelius, D.D.S., M.P.H., Springfield
Harold H. Sitron, D.D.S., Chicago

State Advisory Committee on Group Care Facilities

Don T. Barry, Raymond
Taylor O. Braswell, Belleville
Edward Cannady, M.D., East St. Louis
Bert Cohn, Okawville
Mrs. Rachel Dodson, Herrin
Markham D. Hay, Rockford
Mrs. Bernice Hover, Chicago
Elmer Johnson, Joliet
Mrs. Laverta Johnson, Chicago
Mrs. Jeannette Kramer, Palatine
Robert E. Lanier, Springfield
Roger F. Sondag, M.D., M.P.H., Springfield

DIVISION OF VOCATIONAL REHABILITATION

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical education pursuant to the Federal Vocational Education Act as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Ex Officio:

Director of Agriculture
Director of Labor
Director of Mental Health
Director of Public Health
Director of Registration and Education
Superintendent of Public Instruction

Appointive Members (appointed by Governor):

Lee Chapman, Springfield
William Gellman, Ph.D., Chicago
Edward I. Elisberg, M.D., Highland Park
Gail Warden, Chicago
Guy R. Renzaglia, Ph.D., Carbondale
William R. Rutherford, Peoria

Executive Officers:

For vocational education: Ray Page,
Superintendent of Public Instruction
For vocational rehabilitation: Alfred Slicer
Director, Division of Vocational Rehibilitation

Division of Vocational Rehabilitation

Alfred Slicer, Director
623 East Adams, Springfield 62706

Division of Vocational and Technical Education

Sherwood Dees, Acting Director
405 Centennial Building, Springfield 62706

STATUTORY BOARDS AND COMMISSIONS

(Allied with Public Health Operations)

Air Pollution Control Board

John G. Warren, Moline, *Chairman*
Dr. Albert Crewe, Palos Park
Edgar Peske, Lake Forest
Franklin D. Yoder, M.D., Springfield
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PACKAGED DISASTER HOSPITALS IN ILLINOIS

ADAMS
Quincy—55080
General Stores Bldg., Soldiers & Sailors Home
ALEXANDER
Cairo—55455
City Warehouse, 401 Ohio St.
BOONE
Belvidere—010-50205
Main Hospital Building, 1005 Julian St.
BUREAU
Princeton—010-0052
City Hall, 2 S. Main St. Ref: Perry Memorial Hospital
CARROLL
Savanna—57264
Army Ordnance Depot, Savanna, Gen: Bldg. 413, Heated: Bldg. 127, Flam: Bldg. 938, Ref: Savanna Frozen Food Locker, 1817 Chicago Ave.
CHAMPAIGN
Champaign—62409
Illinois Power Company, 41 E. University, Ref: Univ. Central Food Store: 1321 S. Oak
CHRISTIAN
Pana—010-50580
Pana Comm. Hospital, S. Locus St.

CLAY

Flora—57262
Old Power & Light Bldg., 221 W. South St.

COLES

Charleston—57265
Eastern Illinois University Book Store, 7th St., Basement, Ref: Pemberton Hall, Gen: Lanty Gym

Charleston—62406
Jefferson Jr. High School, 801 Jefferson St., Ref: Higgins Grocery, 407-7th St.

Mattoon—55254
Moody Mfg. Co., 1321 S. 19th St., Ref: Hornes Frozen Food, 301 S. 18th St.

COOK

Chicago Heights—55093
City Hall, 1431 Chicago Rd., Ref: St. James Hospital, Chicago Rd. & 14

Oak Forest—62410
Cottage #10, Oak Forest Hospital, 159 & Cicero Ave., Ref: South Bldg.

Oak Forest—62411
Cottage #10, Oak Forest Hospital, 159 & Cicero Ave., Ref: South Bldg.

Palatine—57782
Village Hall, 54 S. Brockway

Skokie—54028
G. D. Searle & Co., Bldg. A, Searle Pkwy.

DEKALB

DeKalb—010-50207
DeKalb Public Hospital, 4th & Grove Streets

Sandwich—010-50236
City Hall, Railroad and Pearle Sts., Narcotics Hospital

DOUGLAS

Tuscola—57266
Court House, Ref: Tuscola Locker Serv.

DUPAGE

Elmhurst—010-50110
DuPage Memorial Hospital, Avon & Schiller

Wheaton—57330
County Convalescent Home, O.S. 370 County Farm Rd., Flam: County CD Office

Winfield—010-50565
Central DuPage Hospital

EDGAR

Paris—62408
Houston Bldg., 120-126 E. Wood, Ref: Co. Locker Serv., 301 W. Blackburn

FRANKLIN

West Frankfort—55064
New Era Bldg., 105 S. Monroe, Ref: Ice Plant, 305 S. Logan

FULTON

Canton—010-50106
City Garage, Van Buren Court, Ref: Graham Hospital

GRUNDY

Gardner—010-50445
Garfield Township Bldg., Flam: Fire Department Bldg., Affiliation, Morris Hospital, Morris

HENDERSON

Oquawka—55083
Old Opera House, Ref: Wm. Lock's Tavern

IROQUOIS

Askum—55082
Lawson Contracting Co., Ref: Reichert Locker

JACKSON

Murphysboro—62469
Courthouse, 11th & Walnut, Ref: Memorial Hospital

JERSEY

Jerseyville—010-50298
General Highway Garage, Ref: Raiky Locker Plant

KANE

Aurora—55353
East Aurora High School, 779-5th Ave., Ref: Aurora Locker Co., 36 N. Lincoln

KANE

Elgin—55076
Elgin State Hospital Adm. Bldg., Ref: General Stores, Generator: Garage

Elgin—010-50405
Sherman Hospital, 934 Center St.

St. Charles—010-50199
Delmor Hospital, 975 N. Fifth, Ref: Ill. Cleaners & Dryers, 315 E. Main St.

KANKAKEE

Kankakee—55094
Park Div. Garage, 100-5th Ave., Ref: St. Mary's Hospital

Kankakee—010-50566
St. Mary's Hospital

Manteno—010-50584
Kankakee State Hospital, 100 E. Jeffery

Manteno—010-50120
Manteno State Hospital, Silvis Bldg. #1, Ref: & Inf: Gen. Stores Bldg.

KNOX

Galesburg—55075
Knox County Courthouse, Cherry & E. South St., Heat: Ferris Furn. Co., 471 S. Mulberry St., Ref: Galesburg Cottage Hospital

Galesburg—55078
Galesburg State Research Hospital, Warehouse Bldg., N. Seminary St., Ref: Stores Bldg.

Galesburg—55079
Galesburg State Research Hospital, Warehouse Bldg., N. Seminary St., Ref: Stores Bldg.

LAKE

Highland Park—57263
Water Filtration Plant, 1701 St. John Ave.

LASALLE

Ottawa—55356
Libby-Owens Ford Glass Plant, SA: Old Post Office Bldg., 309 Madison, Ref: Ottawa Milk Product., 1219 Fulton

LEE

Dixon—010-50051
Dixon State School, Garages 19-20-21, Ref: Basement, Gen. Stores

LIVINGSTON
Pontiac—010-50157
County Nursing Home, R.R. #1

LOGAN
Lincoln—55086
Lincoln State School, 816 S. State St., Ref: Stores Bldg.
Lincoln—55366
Lincoln Warehouse, 100 S. Sangamon, Ref: Cold Storage Bldg. & Lincoln State School

McLEAN
Normal—55091
Ill. Soldiers & Sailors, Children's School Hospital, Ref: General Stores

McHENRY
McHenry—010-50939
McHenry High School, 1012 N. Green St.

MACON
Decatur—55347
Macon County Building, 253 E. Wood, Ref: County TB Sanitorium, 400 Hay St.,

MACOUPIN
Carlinville—010-50373
Business Building, 35½ Daley St., Ref: Prairie Farm Dairies Store, Rt. 4, Generator: High School

MADISON
Alton—55089
County Civil Defense Bldg., 513 E. Third St.
Edwardsville—55398
LeClair Grade School, New Franklin Rd., Ref: LeClair Grade School, Frozen Food Locker Plant

MARION
Centralia—55117
Chapel Bldg., Elmwood Cemetery, Ref: Frozen Food Locker Plant, 324 E. Broadway

MASON
Havana—56005
C & I R.R. Depot, Rt. 136, Heated: High School, Ref: Morgan's Market, 305 E. Main St.

MASSAC
Metropolis—55453
Power & Light Building, 101 Front St., Ref: Cummings Spec. Locker, 1210 E. Fifth St.

MONTGOMERY
Litchfield—010-50560

MORGAN
Jacksonville—010-50420
Jacksonville State Hospital, Basement, Veterans Diag. Bldg. Ref: 2nd Floor, Stores Bldg.

PEORIA
Bartonville—62407
Civil Defense Center, Abbott Center, Peoria State Hospital
Peoria—62413
Carson, Pirie, Scott & Co., Central Distribution 801 S. W. Washington

PERRY
DuQuoin—55454
Heat Plant & Ref: Marshall Browning Hospital, 900 N. Washington, General: Ill. Central Depot, Oak St.

RANDOLPH
Chester—010-50225
Chester Memorial Hosp., 1900 State St.
Red Bud—010-50152
Gen: Schreiber Warehouse, 119 W. Red Bud St., Heated: Basement of City Hall

RICHLAND
Olney—55412
County Court House, Main St.

SALINE
Muddy—55090
Old Grade School

SCHUYLER
Rushville—57323
Scripps Park Country Club, Ref: Culbertson Hospital and Barllow Packing Co.

TAZEWELL
Pekin—010-50603
Pekin High School, East Campus, Ref: Memorial Hospital

UNION
Anna—55092
Anna State Hospital, Bldg. #4 and Hamilton Hall

VERMILION
Danville—55349
St. Elizabeth's Hospital, 600 Sager Ave.
Danville—55350
St. Elizabeth's Hospital, 600 Sager Ave.

WABASH
Mt. Carmel—62404
City Bldg., 3rd and Market Sts., Ref: Wabash General Hospital

WARREN
Monmouth—010-50224
Wakefield Warehouse, 314 East 6th St.

WHITESIDE
Erie—57304
Erie High School (Basement), Ref: Erie Locker Plant, Main St.
Sterling—62405
City Hall, 212 Third Ave., Ref: Community General Hospital

WILL
Joliet—54005
Barrett's Hardware, Bldg. #4, 342 Henderson St., Heated: Bldg. next to Bldg. #4, Ref: Silver Cross Hospital

WINNEBAGO
Rockford—62403
Whitehead School, 2324 Ohio Pkwy., Ref: Thomas Jefferson High School

PDH Training Units In Illinois

CHAMPAIGN
Rantoul—61866
City Civil Defense

DuPAGE
Elmhurst—53034
York Community High School

JACKSON
Carbondale—53031
Southern Illinois University
MARION
Salem—56006
Salem CD Headquarters, Bryan Park
PEORIA
Peoria—53036
Peoria State Hospital
ST. CLAIR
Belleville—53030
1505 Caseyville Avenue, P.O. Box 271
SANGAMON
Springfield—53037
Douglas Grade School, 444 W. Reynolds St.
VERMILION
Danville—53032
St. Elizabeth's Hospital, 600 Sager Ave.
WINNEBAGO
Rockford—53038
Presidential Court, Loves Park

APPROVED LABORATORIES—PKU—FLUOROMETRIC TEST*

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Alton Memorial Hospital Laboratory
AURORA
Clinical Laboratory, Aurora Medical Park
BENTON
Franklin Hospital
CHAMPAIGN
Burnham City Hospital
CHICAGO
Chicago Wesleyan Memorial Hospital
Children's Memorial Hospital Laboratory
Columbus Hospital Laboratory
Edgewater Hospital
Mercy Hospital
Michael Reese Hospital
Mt. Sinai Hospital
Presbyterian-St. Luke's Hospital
Provident Hospital
State Laboratory
University of Illinois, Research and Educational Hospital
Walther Memorial Hospital
Weiss Memorial Hospital
ELGIN
Sherman Hospital Laboratory
EVANSTON
St. Francis Hospital Laboratory
DANVILLE
Lake View Memorial Hospital
ELGIN
Sherman Hospital
EVANSTON
Evanston Hospital
St. Francis Hospital
FREEPORT
Freeport Memorial Hospital
MT. CARMEL
Wabash General Hospital
NAPERVILLE
Edward Hospital
OAK LAWN
Christ Community Hospital
OAK PARK
Oak Park Hospital
West Suburban Hospital
PEORIA
St. Francis Hospital
ROCKFORD
Swedish-American Hospital
SKOKIE
Skokie Valley Community Hospital
URBANA
Carle Hospital Clinic
Mercy Hospital Clinic

*These laboratories are approved for the use of this procedure for both screening and quantitative determinations.

POISON CONTROL CENTERS IN ILLINOIS

AURORA
Copley Memorial Hospital
Lincoln & Weston Avenues
896-4611, Ext. 725
St. Charles Hospital
400 E. New York Street
897-8714, Ext. 50
BELLEVILLE
Memorial Hospital
4501 North Park Dr.
233-7750, Ext. 286
BERWYN
MacNeal Memorial Hospital
3249 S. Oak Park Ave.
484-2211 Ext. 311 and 312
BLOOMINGTON
Mennonite Hospital
807 North Main St.
823-8241, Ext. 311
St. Joseph's Hospital
2200 E. Washington St.
829-9481, Ext. 354
CAIRO
St. Mary's Hospital
2020 Cedar St.
734-2400, Ext. 45
CANTON
Graham Hospital Association
210 W. Walnut St.
647-5240, Ext. 48

CARBONDALE
Doctors Hospital
404 W. Main St.
457-4101, Ext. 23
CENTRALIA
St. Mary's Hospital
400 N. Pleasant Ave.
532-6731, Ext. 626
CHAMPAIGN
Burnham City Hospital
311 E. Stoughton St.
337-2533
CHANUTE AIR FORCE BASE*
United States Air Force Hospital
893-3111, Ext. 6234 and 6233
CHESTER
Memorial Hospital
1900 State St.
826-2367, Ext. 44
CHICAGO
Children's Memorial Hospital
2300 Children's Plaza
348-4040, Ext. 338
Cook County Hospital
1825 West Harrison St.
633-6526; Night 633-6541
University of Illinois Hospitals
840 South Wood St.
663-6801
Mercy Hospital
2510 Martin Luther King Dr.
842-4700
Michael Reese Hospital
29th Street & Ellis Ave.
225-5525, Ext. 761
Night Ext. 261
Mt. Sinai Hospital
15th & California
277-4000, Ext. 297-8
Municipal Contagious Disease San.
3026 South California Ave.
247-5700
Resurrection Hospital
7435 West Talcott Ave.
774-8000, Ext. 235-6
Wyler Silvain and Arma Children's Hospital
950 E. 59th St.
684-6100 Ext. 6231
Night 5412
DANVILLE
Lake View Memorial Hospital
812 N. Logan Ave.
446-7200, Ext. 765-78
St. Elizabeth's Hospital
600 Sager St.
442-6300
DECATUR
Decatur-Macon County Hospital
2300 N. Edward St.
877-8121, Ext. 675-6

*Limited for treatment of military personnel and families, except for indicated emergencies.

St. Mary's Hospital
1800 E. Lake Shore Dr.
429-2966, Ext. 640
DES PLAINES
Holy Family Hospital
100 North River Road
299-2281, Ext. 856
EAST ST. LOUIS
Christian Welfare Hospital
1509 Illinois Ave.
874-7076, Ext. 231
St. Mary's Hospital
129 North 8th St.
274-1900
EFFINGHAM
St. Anthony's Hospital
503 North Maple St.
342-2121, Ext. 67
ELGIN
St. Joseph's Hospital
277 Jefferson Ave.
741-5400, Ext. 69
Sherman Hospital
934 Center St.
742-9800, Ext. 681-3
ELMHURST
Memorial Hospital of DuPage County
315 Schiller St.
833-1400
EVANSTON
Community Hospital
2040 Brown Ave.
869-5044, Ext. 54
Night Ext. 58
Evanston Hospital
2650 Ridge Ave.
492-6460
St. Francis Hospital
355 Ridge Ave.
492-2440
EVERGREEN PARK
Little Company of Mary Hospital
2800 W. 95th St.
422-6200, Ext. 1211
FAIRBURY
Fairbury Hospital
519 South Fifth St.
692-2346
FREEPORT
Freeport Memorial Hospital
420 South Harlem Ave.
233-4131, Ext. 228
GALENA
Northwestern Illinois Community Hospital
Summit Street
777-1340
GALESBURG
Galesburg Cottage Hospital
674 North Seminary St.
343-4121, Ext. 356
St. Mary's Hospital
239 South Cherry St.
343-3161, Ext. 203

GRANITE CITY
St. Elizabeth's Hospital
2100 Madison Ave.
876-2020, Ext. 224-257
HARVEY
Ingalls Memorial Hospital
15510 Page Ave.
333-2300
HIGHLAND
St. Joseph's Hospital
1515 Main St.
654-2171
HIGHLAND PARK
Highland Park Hospital Foundation
718 Glenview Ave.
432-8000, Ext. 561-3
HINSDALE
Hinsdale San. & Hospital
120 North Oak St.
323-2100, Ext. 336-8
HOOPESTON
Hoopeston Community Memorial Hospital
701 E. Orange
283-5531
JACKSONVILLE
Passavant Memorial Area Hospital
1600 West Walnut
245-9541
JOLIET
St. Joseph's Hospital
333 N. Madison St.
725-7133, Ext. 679-93
Silver Cross Hospital
600 Walnut St.
727-1711, Ext. 731
KANKAKEE
St. Mary's Hospital
150 South Fifth St.
939-2531, Ext. 735
KEWANEE
Kewanee Public Hospital
719 Elliott St.
3361, Ext. 219
LAKE FOREST
Lake Forest Hospital
660 North Westmoreland Road
234-5600, Ext. 608
LASALLE
St. Mary's Hospital
1015 O'Conor Ave.
223-0607, Ext. 84, Night Ext. 46
LIBERTYVILLE
Condell Memorial Hospital
Cleveland & Stewart Aves.
362-2900, Ext. 325-6
LINCOLN
Abraham Lincoln Memorial Hospital
315 Eighth St.
732-2161, Ext. 365
MACOMB
McDonough District Hospital
525 East Grant St.
833-4101
MATTOON
Mem. Dist. Hosp. of Coles County
2101 Champaign Ave.
234-8881, Ext. 43,
Night Ext. 29
McHENRY
McHenry Hospital
3516 West Waukegan Road
385-2200, Ext. 614
MELROSE PARK
Westlake Hospital
1225 Superior St.
681-3000, Ext. 239, 226
MENDOTA
Mendota Community Hospital
Memorial Drive & Route 51
2131, Ext. 22; Night Ext. 20
MOLINE
Moline Public Hospital
635-10th Ave.
762-3651, Ext. 232
MONMOUTH
Community Memorial Hospital
W. Harlem Ave.
734-3141, Ext. 250
MOUNT CARMEL
Wabash General Hospital
1418 College Drive
262-4121
MOUNT VERNON
Good Samaritan Hospital
605 North Twelfth St.
242-4600, Ext. 303,
Night Ext. 385
NAPERVILLE
Edward Hospital
South Washington St.
355-0450, Ext. 26
NORMAL
Brokaw Hospital
Virginia at Franklin Ave.
829-7685, Ext. 274
OAK LAWN
Christ Community Hospital
4440 West 95th St.
423-7000, Ext. 659, 600, 601
OAK PARK
West Suburban Hospital
518 North Austin Blvd.
383-6200, Ext. 605
OLNEY
Richland Memorial Hospital
800 East Locust St.
395-2131, Ext. 226
OTTAWA
Ryburn Memorial Hospital
701 Clinton St.
433-3100
PARK RIDGE
Lutheran General Hospital
1775 Dempster St.
692-2210

PEKIN
Pekin Memorial Hospital
Corner of 14th & Court St.
347-1151, Ext. 242

PEORIA
Methodist Hospital
221 Northeast Glen Oak Ave.
685-6511, Ext. 250, 360
Proctor Community Hospital
5409 North Knoxville Ave.
691-4702, Ext. 791
St. Francis Hospital
530 Northeast Glen Oak Ave.
674-7731, Ext. 514

PERU
Peoples Hospital
925 West Street
223-3300

PITTSFIELD
Illini Community Hospital
620 West Washington St.
285-2113

QUINCY
Blessing Hospital
1005 Broadway
222-3270, Ext. 211
St. Mary's Hospital
1415 Vermont St.
223-1200, Ext. 275

ROCKFORD
Rockford Memorial Hospital
2400 North Rockton Ave.
968-6861, Ext. 441
St. Anthony's Hospital
6666 E. State St.
398-7600
Swedish-American Hospital
1316 Charles St.
968-6898, Ext. 602

ROCK ISLAND
St. Anthony's Hospital
767-30th St.
788-7631, Ext. 771

ST. CHARLES
Delnor Hospital
975 North Fifth Ave.
584-3300, Ext. 218

SPRINGFIELD
Memorial Hospital
First and Miller Sts.
528-2041, Ext. 333
St. John's Hospital
701 E. Mason St.
544-6451, Ext. 375

STREATOR
St. Mary's Hospital
111 E. Spring
672-3189

URBANA
Carle Hospital
611 W. Park St.
337-3311
Mercy Hospital
1412 West Park Ave.
337-2131

WAUKEGAN
St. Therese Hospital
West Washington St.
688-6470
Night 688-6471
Victory Memorial Hospital
1324 North Sheridan Road
688-4181

WOODSTOCK
Memorial Hospital for McHenry County
527 West South St.
338-2500, Ext. 32

ZION
Zion-Benton Hospital,
2500 Emmaus Ave.
872-4561, Ext. 240

HOSPITALS

The Illinois Department of Public Health is responsible for implementing the Hospital Licensing Act, excerpts from which follows:

Section 2. The purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in hospitals, (2) for the construction, maintenance, and operation of hospitals which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals, and (3) that will have regard to the necessity of determining that a person establishing a hospital have the qualifications, background, character and financial resources to adequately provide a proper standard of hospital service for the community.

Hospital Licensing Requirements

To implement the Hospital Licensing Act, the Department of Public Health has patient requirements. The following cover the medical staff.

1. The medical staff shall be composed only of physicians and dentists licensed by the Illinois Department of Registration and Education in accordance, respectively, with provisions of the Medical Practice Act and Dental Practice Act.

2. The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the governing board. The bylaws, rules and regulations shall specifically provide:

a. for eligibility for staff membership;
b. for such divisions and departments as are warranted, (as a minimum, Active and Consulting divisions are required)
c. for such officers and/or committees as are warranted; however, committees shall be designed to be responsible for medical records and for pharmacy and therapeutics;
d. for determination of qualifications and privileges;
e. that medical staff meetings be held regularly, and that written minutes of all meetings be kept;
f. for review and analysis of the clinical experience of the hospital at regular intervals —the medical records of patients to be the basis for such review and analysis;
g. that tissue removed at operation shall be examined by a qualified pathologist and that the findings shall be made a part of the patient's medical record;
h. for consultation between medical staff members in complicated cases; and
i. for keeping complete medical records.

Section B. Supervision of Patient Care

All persons admitted to the hospital shall be under the professional care of a member of the medical staff.

Section C. Orders for Medication and Treatment

No medication or treatment shall be given to a patient except on the written order of a member of the medical staff.

Section D. Tissue Examination

All tissue removed at operation shall be examined by a qualified pathologist and the findings shall be made a part of the patient's hospital medical record. A tissue committee of the medical staff is highly recommended.

The governing board shall provide that one or more physicians shall be available at all times for emergencies.

GENERAL HOSPITALS

(For Identification—see footnote, page 488)

ALEDO (Mercer)
Mercer County Hospital (E-63)
ALTON (Madison)
**Alton Memorial Hospital (B-210)
*St. Anthony's Hospital (B-140)
**St. Joseph's Hospital (B-152)
AMBOY (Lee)
Amboy Public Hospital (B-15)
ANNA (Union)
Union County Hospital District (F-67)
ARLINGTON HEIGHTS (Cook)
**Northwest Community Hospital (B-223)
AURORA (Kane)
**Copley Memorial Hospital (B-200)
Kane County Springbrook Sanitarium (E-57)
*St. Charles Hospital (B-107)
*St. Joseph Mercy Hospital (B-107)
AVON (Fulton)
Saunders Hospital (B-24)
BEARDSTOWN (Cass)
*Schmitt Memorial Hospital (D-50)
BELLEVILLE (St. Clair)
**Memorial Hospital (B-151)
†*St. Elizabeth's Hospital (B-294)
BELVIDERE (Boone)
*Highland Hospital, Inc. (B-65)
*St. Joseph's Hospital (B-100)
BENTON (Franklin)
*The Franklin Hospital (F-125)
BERWYN (Cook)
**MacNeal Memorial Hospital (B-423)
BLOOMINGTON (McLean)
*Mennonite Hospital (B-130)
*St. Joseph's Hospital (B-158)
BLUE ISLAND (Cook)
**St. Francis Hospital (B-220)
BREESE (Clinton)
*St. Joseph's Hospital (B-42)
CAIRO (Alexander)
Alexander County Tuberculosis Sanitarium (E-36)
*St. Mary's Hospital (B-130)
CANTON (Fulton)
*Graham Hospital Association (B-152)
CARBONDALE (Jackson)
*Doctors Hospital (B-60)
*Holden Hospital (B-55)
CARLINVILLE (Macoupin)
*Carlinville Area Hospital (B-68)
CARMI (White)
*Carmi Township Hospital (H-63)
CARROLLTON (Greene)
Thomas H. Boyd Memorial Hospital (B-43)
CARTHAGE (Hancock)
*Memorial Hospital (B-80)
CASEYVILLE (St. Clair)
Pleasant View Sanitorium (E-100)
CENTRALIA (Marion)
**St. Mary's Hospital (B-117)
CHAMPAIGN (Champaign)
**Burnham City Hospital (D-161)
*Cole Hospital (C-61)
CHARLESTON (Coles)
*Charleston Community Memorial Hospital, Inc., (B-65)
CHESTER (Randolph)
*Memorial Hospital (F-52)

CHICAGO (Cook)
*Alexian Brothers Hospital (B-240)
*American Hospital of Chicago (B-168)
**Augustana Hospital (B-350)
**Belmont Community Hospital (B-157)
*Bethany Brethren Hospital (B-59)
*Bethany Methodist Hospital (B-157)
*Bethesda Hospital (B-99)
*Booth Memorial Hospital (B-25)
*Central Community Hospital (B-93)
*Cermak Memorial Hospital (D-129)
*Charles H. & S. Rachael Schwab Rehabilitation Hospital (B-61)
*Chicago Eye, Ear, Nose and Throat Hospital (C-37)
**Chicago Osteopathic Hospital (B-171)
*Chicago Tuberculosis Sanitarium (I-330)
†*Chicago Wesley Memorial Hospital (B-654)
*Children's Memorial Hospital (B-237)
**Columbus Hospital (B-407)
*Cook County Hospital (E-2,747)
Doctors General Hospital (B-86)
Doctors General Hospital, Unit II (B-96)
*Edgewater Hospital (B-334)
**Englewood Hospital (B-159)
*Evangelical Hospital of Chicago (B-174)
*Forkosh Memorial Hospital (B-150)
**Frank Cuneo Hospital (B-178)
*Franklin Boulevard Community Hospital (B-110)
**Garfield Park Community Hospital (B-141)
†**Grant Hospital of Chicago (B-339)
Halco Sanitarium Inc. (C-10)
*Henrotin Hospital (B-95)
**Holy Cross Hospital (B-330)
*Hospital of St. Anthony de Padua (B-209)
Ida Mae Scott Hospital (C-15)
*Illinois Central Hospital (B-301)
†**Illinois Masonic Hospital (B-544)
*Jackson Park Hospital (C-184)
LaRabida Jackson Park Sanitarium (B-104)
†**Loretto Hospital (B-163)
**Louis A. Weiss Memorial Hospital (B-250)
*Louis Burg Hospital (B-114)
*Lutheran Deaconess Hospital (B-183)
*Martha Washington Hospital (B-58)
**Mary Thomson Hospital (B-112)
†**Mercy Hospital (B-355)
†**Michael Reese Hospital and Medical Center (B-994)
†**Mount Sinai Hospital of Chicago (B-391)
*Municiple Contagious Disease Hospital (D-100)
*Municiple Tuberculosis Sanitarium (D-1,081)
*Northwest Hospital, Inc. (C-225)
**Norwegian-American Hospital, Inc. (B-222)
†**Passavant Memorial Hospital (B-351)
†**Presbyterian-St. Luke's Hospital (B-839)
*Provident Hospital and Training School (B-204)
**Ravenswood Hospital Association (B-275)
*Rehabilitation Institute of Chicago (B-65)
**Resurrection Hospital (B-260)
*Roosevelt Memorial Hospital (B-115)
*Roseland Community Hospital (B-131)
**St. Anne's Hospital (B-405)
*St. Bernard's Hospital (B-229)
*St. Elizabeth's Hospital (B-322)
**St. Frances Xavier Cabrini Hospital (B-200)
*St. George Hospital (B-128)
†**St. Joseph Hospital (B-488)
**St. Mary of Nazareth Hospital (B-280)
*St. Vincent's Infant Hospital (B-65)
*Shriners Hospital for Crippled Children (Chicago Unit) (B-68)
**South Chicago Community Hospital (B-300)
**South Shore Hospital (B-189)
**Swedish Covenant Hospital (B-240)
†**University of Chicago Hospitals and Clinics (B-661)
†*University of Illinois Research and Educational Hospitals (I-605)
*The Von Solbrig Memorial Hospital, Inc. (A-102)
*Walther Memorial Hospital (B-222)
*Woodlawn Hospital (B-145)
CHICAGO HEIGHTS (Cook)
**St. James Hospital (B-420)
CHRISTOPHER (Franklin)
*The Miners Hospital (B-34)
CLIFTON (Iroquois)
Central Hospital (B-40)
CLINTON (DeWitt)
*John Warner Hospital (D-45)
DANVILLE (Vermilion)
**Lake View Memorial Hospital (B-237)
**St. Elizabeth Hospital (B-180)
*Vermilion County Tuberculosis Dispensary and Hospital (E-61)
DECATUR (Macon)
**Decatur and Macon County Hospital (B-363)
*Macon County Tuberculosis Sanitorium (E-40)
*St. Mary's Hospital (B-389)
*The Wabash Memorial Hospital (B-61)
DeKALB (DeKalb)
*DeKalb Public Hospital (D-110)
DES PLAINES (Cook)
**Holy Family Hospital (B-236)
DIXON (Lee)
*Dixon Public Hospital (B-120)
DOLTON (Cook)
*Thomsen Clinic Hospital (B-6)
DU QUOIN (Perry)
*Marshall Browning Hospital (B-66)
EAST ST. LOUIS (St. Clair)
*Centreville Township Hospital (H-145)
*Christian Welfare Hospital (B-194)
*St. Mary's Hospital (B-300)
EDWARDSVILLE (Madison)
Madison County TB Sanitorium (E-87)
EFFINGHAM (Effingham)
*St. Anthony Memorial Hospital (B-126)

ELDORADO (Saline)
Ferrell Hospital (C-48)
Pearce Hospital Foundation (B-33)
ELGIN (Kane)
**St. Joseph Hospital (B-154)
**Sherman Hospital Association (B-335)
ELK GROVE VILLAGE (Cook)
*St. Alexius Hospital (B-225)
ELMHURST (DuPage)
**Memorial Hospital of DuPage County (B-413)
EUREKA (Woodford)
*Eureka Hospital (C-31)
EVANSTON (Cook)
*Community Hospital of Evanston (B-54)
†**Evanston Hospital Association (B-467)
*Northwestern University Student Health Service Hospital (B-44)
**St. Francis Hospital (B-343)
EVERGREEN PARK (Cook)
†**Little Company of Mary Hospital (B-559)
FAIRBURY (Livingston)
*Fairbury Hospital (B-86)
FAIRFIELD (Wayne)
*Fairfield Memorial Hospital (B-104)
FLORA (Clay)
*Clay County Hospital (E-52)
FREEPORT (Stephenson)
*Freeport Memorial Hospital (B-186)
GALENA (Jo Daviess)
*Northwestern Illinois Community Hospital (F-31)
GALESBURG (Knox)
**Galesburg Cottage Hospital (B-191)
*St. Mary's Hospital (B-134)
GENESEO (Henry)
*Hammond-Henry District Hospital (F-66)
GENEVA (Kane)
**Community Hospital (B-116)
GIBSON CITY (Ford)
*Gibson Community Hospital (B-45)
GRANITE CITY (Madison)
**St. Elizabeth Hospital (B-248)
GREENEVILLE (Bond)
*Edward A. Utlaut Memorial Hospital (B-72)
HARRISBURG (Saline)
Doctors Hospital of Harrisburg, Inc. (C-80)
HARVARD (McHenry)
*Harvard Community Memorial Hospital (F-40)
HARVEY (Cook)
*Ingalls Memorial Hospital (B-309)
HAVANA (Mason)
*Mason District Hospital (F-48)
HAZEL CREST (Cook)
*South Suburban Hospital Foundation (B-57)
HERRIN (Williamson)
*Herrin Hospital (B-131)
HIGHLAND (Madison)
*St. Joseph's Hospital (B-133)
HIGHLAND PARK (Lake)
**The Highland Park Hospital Foundation (B-196)
HILLSBORO (Montgomery)
*Hillsboro Hospital (B-65)
HINSDALE (DuPage)
†*Hinsdale Sanitarium and Hospital (B-353)
HOOPESTON (Vermilion)
*Hoopestown Community Memorial Hospital (B-44)
HOPEDALE (Tazewell)
*Hopedale Hospital (B-44)
JACKSONVILLE (Morgan)
*Holy Cross Hospital (B-122)
Oaklawn, Morgan Co. Tuberculosis Sanitorium (E-40)
*Passavant Memorial Area Hospital (B-150)
JERSEYVILLE (Jersey)
*Jersey Community Hospital (F-54)
JOLIET (Will)
†**St. Joseph Hospital (B-429)
*Silver Cross Hospital (B-271)
Sunny Hill Sanitorium (E-60)
KANKAKEE (Kankakee)
*Riverside Hospital (B-136)
*St. Mary's Hospital (B-262)
KEWANEE (Henry)
*Kewanee Public Hospital (B-75)
*St. Francis Hospital (B-87)
LA GRANGE (Cook)
**Community Memorial General Hospital (B-223)
LA HARPE (Hancock)
LaHarpe Hospital (B-19)
LAKE FOREST (Lake)
**Lake Forest Hospital (B-101)
LASALLE (LaSalle)
*St. Mary's Hospital (B-123)
LAWRENCEVILLE (Lawrence)
*Lawrence County Memorial Hospital (E-78)
LIBERTYVILLE (Lake)
**Condell Memorial Hospital (B-91)
LINCOLN (Logan)
*Abraham Lincoln Memorial Hospital (B-154)
LITCHFIELD (Montgomery)
St. Francis Hospital (B-134)
MACKINAW (Tazewell)
Oak Knoll Sanitorium (E-40)
MACOMB (McDonough)
*McDonough District Hospital (F-104)
St. Francis Hospital (B-60)
MANTENO (Kankakee)
Hillman Memorial Hospital (C-26)
MARION (Williamson)
*Marion Memorial Hospital (D-75)
MATTOON (Coles)
**Memorial District Hospital of Coles County (F-99)
McHENRY (McHenry)
**McHenry Hospital (B-43)
McLEANSBORO (Hamilton)
*Hamilton Memorial Hospital (F-32)
MELROSE PARK (Cook)
**Gottlieb Memorial Hospital (B-202)
**Westlake Community Hospital (B-141)

MENDOTA (LaSalle)
*Mendota Community Hospital (B-58)
METROPOLIS (Massac)
**Massac Memorial Hospital (F-57)
MOLINE (Rock Island)
**Lutheran Hospital (B-270)
*Moline Public Hospital (D-240)
MONMOUTH (Warren)
*Monmouth Hospital (D-81)
MONTICELLO (Piatt)
*The John and Mary E. Kirby Hospital (B-35)
MOOSEHEART (Kane)
Mooseheart Hospital (B-43)
MORRIS (Grundy)
*Morris Hospital (B-51)
MORRISON (Whiteside)
*Morrison Community Hospital (F-32)
MOUNT CARMEL (Wabash)
*Wabash General Hospital District (F-71)
MOUNT VERNON (Jefferson)
**Good Samaritan Hospital (B-110)
Jefferson County Memorial Hospital (B-50)
Mt. Vernon State Tuberculosis Sanitarium (I-125)
MURPHYSBORO (Jackson)
*St. Joseph Memorial Hospital (B-64)
NAPERVILLE (DuPage)
*Edward Hospital (F-110)
NASHVILLE (Washington)
*Washington County Hospital (F-36)
NORMAL (McLean)
*Brokaw Hospital (B-142)
NORTHLAKE (Cook)
Northlake Community Hospital (B-105)
OAK FOREST (Cook)
Oak Forest Hospital (E-2,207)
OAK LAWN (Cook)
**Christ Community Hospital (B-348)
OAK PARK (Cook)
*Oak Park Hospital (B-246)
**West Suburban Hospital (B-389)
OLNEY (Richland)
**Richland Memorial Hospital (E-150)
OREGON (Ogle)
*Warmolts Clinic (C-25)
OTTAWA (LaSalle)
Highland Sanitorium and Convalescent Home of LaSalle County (E-19)
Ottawa General Hospital (C-42)
**Ryburn Memorial Hospital (D-117)
PANA (Christian)
*Huber Memorial Hospital (B-89)
PARIS (Edgar)
*Hospital & Medical Foundation of Paris, Inc. (B-66)
PARK RIDGE (Cook)
†*Lutheran General Hospital (B-326)
PAXTON (Ford)
*Paxton Community Hospital (B-39)
PEKIN (Tazewell)
*Pekin Memorial Hospital (B-181)
PEORIA (Peoria)
†**The Methodist Hospital of Central Illinois (B-496)
Peoria Municiple Tuberculosis Sanitarium (D-79)
*Proctor Community Hospital (B-210)
†**St. Francis Hospital (B-623)
PERU (LaSalle)
*Peoples Hospital (B-100)
PINCKNEYVILLE (Perry)
*Pinckneyville Community Hospital (F-52)
PITTSFIELD (Pike)
*Illini Community Hospital (B-100)
PONTIAC (Livingston)
Livingston County Sanitorium (E-46)
*St. James Hospital (B-65)
PRINCETON (Bureau)
*Perry Memorial Hospital (D-98)
QUINCY (Adams)
**Blessing Hospital (B-237)
Hillcrest, Adams County Tuberculosis Sanitorium (E-38)
†**St. Mary's Hospital (B-246)
RED BUD (Randolph)
*St. Clement's Hospital (B-84)
ROBINSON (Crawford)
*Crawford Memorial Hospital (F-64)
ROCHELLE (Ogle)
*Rochelle Community Hospital (B-38)
ROCKFORD (Winnebago)
*Rockford Memorial Hospital (B-264)
Rockford Municiple Tuberculosis Sanitarium (D-44)
*St. Anthony Hospital (B-252)
†**Swedish-American Hospital (B-321)
ROCK ISLAND (Rock Island)
Rock Island County Tuberculosis Sanitorium (E-71)
†**St. Anthony's Hospital (B-240)
ROSICLARE (Hardin)
*Hardin County General Hospital (B-27)
RUSHVILLE (Schuyler)
*Sarah D. Culbertson Memorial Hospital (F-56)
ST. CHARLES (Kane)
**Delnor Hospital (B-105)
SALEM (Marion)
*Salem Memorial Hospital (B-39)
SANDWICH (DeKalb)
*Sandwich Community Hospital (B-63)
SAVANNA (Carroll)
Savanna City Hospital (D-44)
SHELBYVILLE (Shelby)
*Shelby County Memorial Hospital (B-79)
SKOKIE (Cook)
*Skokie Valley Community Hospital (B-153)
SPARTA (Randolph)
*Sparta Community Hospital (F-30)
SPRINGFIELD (Sangamon)
†*Memorial Hospital (B-402)
†**St. John's Hospital (B-723)
St. John's Sanitorium (B-125)

SPRING VALLEY (Bureau)
*St. Margaret's Hospital (B-141)
STAUNTON (Macoupin)
*Community Memorial Hospital (B-62)
STERLING (Whiteside)
**Community General Hospital (D-144)
Home Hospital (B-24)
STREATOR (LaSalle)
**St. Mary's Hospital (B-233)
SYCAMORE (DeKalb)
*Sycamore Municipal Hospital (D-70)
TAYLORVILLE (Christian)
**St. Vincent Memorial Hospital (B-155)
TUSCOLA (Douglas)
*Douglas County Jarman Memorial Hospital (E-42)
URBANA (Champaign)
**Carle Memorial Hospital (B-154)
*McKinley Memorial Hospital (I-62)
†**Mercy Hospital (B-250)
Outlook Champaign County Tuberculosis Sanitorium (E-25)
University of Illinois Rehab. Center (I)
VANDALIA (Fayette)
*Fayette County Hospital (F-95)
WATSEKA (Iroquois)
*Iroquois Hospital (B-72)
WAUKEGAN (Lake)
*Lake County General Hospital (E-65)
*Lake County Tuberculosis Sanitorium (E-90)
*St. Therese Hospital (B-280)
*Victory Memorial Hospital (B-352)
WENDRON (LaSalle)
St. Joseph's Health Resort and Sanitarium (B-94)
WEST FRANKFORT (Franklin)
UMWA Union Hospital (B-38)
WHITE HALL (Greene)
White Hall Hospital, Inc. (B-18)
WINFIELD (DuPage)
**Central DuPage Hospital (B-113)
WOOD RIVER (Madison)
*Wood River Township Hospital (H-73)
WOODSTOCK (McHenry)
*Memorial Hospital for McHenry County (B-100)
ZION (Lake)
*Zion-Benton Hospital (C-107)

HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
AURORA (Kane)	Kane County Springbrook Sanitarium (E-57)	TB
CAIRO (Alexander)	Alexander County Tuberculosis Hospital (E-36)	TB
CASEYVILLE (St. Clair)	Pleasant View Sanitorium (E-100)	TB
CHICAGO (Cook)	*Booth Memorial Hospital (B-25)	Maternity
	*Charles H. and Rachel M. Schwab Rehabilitation Hospital (B-61)	Rehabilitation
	*Chicago Eye, Ear, Nose and Throat Hospital (C-37)	EENT
	*Chicago State Tuberculosis Sanitarium (I-336)	TB
	*The Children's Memorial Hospital (B-237)	Pediatric
	Halco Sanitarium, Inc. (C-10)	Alcoholic
	Illinois Children's Hospital-School (I-96)	Rehabilitation, Pediatric
	*Illinois Eye and Ear Infirmary (I-124)	EENT
	Illinois Visually Handicapped Institute (I-52)	Rehabilitation
	*LaRabida Jackson Park Sanitarium (B-104)	Pediatric Chronic
	*Martha Washington Hospital (B-50)	Alcoholic
	*Municipal Contagious Disease Hospital (D-100)	Contagious Disease
	*Municipal Tuberculosis Sanitarium (D-1,081)	TB
	*Rehabilitation Institute of Chicago (B-65)	Rehabilitation
	St. Vincent's Infant Hospital (B-65)	Pediatric
	*Shriners Hospital for Crippled Children (B-68)	Orthopedic, Pediatric
DANVILLE (Vermilion)	Vermilion County Tuberculosis Dispensary and Hospital (E-34)	TB

Hospitals with Special Type of Service (Continued)

DECATUR (Macon)	Macon County Tuberculosis Sanitorium (E-75)	TB
EDWARDSVILLE (Madison)	Madison County TB Sanitorium (E-87)	TB
HINSDALE (Cook)	*The Suburban Cook County Tuberculosis Sanitarium District (G-206)	TB
JACKSONVILLE (Morgan)	Oaklawn, Morgan County Tuberculosis Sanitorium (E-40)	TB
JOLIET (Will)	Sunny Hill Sanitorium (E-60)	TB
MACKINAW (Tazewell)	Oak Knoll Sanitorium (E-40)	TB
MOOSEHEART (Kane)	Moosehart Hospital (B-43)	Pediatric
MOUNT VERNON (Jefferson)	*Mount Vernon State Tuberculosis Sanitarium (I-125)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,463)	Chronic, Rehabilitation
OTTAWA (LaSalle)	Highland Sanatorium and Convalescent Home of LaSalle County (E-82)	TB, Nursing Home
	*Ottawa General Hospital (C-42)	Chronic
PEORIA (Peoria)	*Peoria Municipal Tuberculosis Sanitarium (D-79)	TB
PONTIAC (Livingston)	Livingston County Sanitorium (E-46)	TB
QUINCY (Adams)	Hillcrest, Adams County Tuberculosis Sanitorium (E-38)	TB
ROCKFORD (Winnebago)	Rockford Municipal Tuberculosis Sanitarium (D-100)	TB, Nursing Home
ROCK ISLAND (Rock Island)	*Rock Island County Tuberculosis Sanitorium (E-71)	TB
SPRINGFIELD (Sangamon)	*St. John's Sanitorium (B-125)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanitorium (E-25)	TB
	University of Illinois Rehabilitation Center (I)	Rehabilitation
WAUKEGAN (Lake)	*Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-94)	Medical-Chronic

STATE MENTAL HOSPITALS

ALTON (Madison)
Alton State Hospital (1,371)
ANNA (Union)
Anna State Hospital (1,838)
CHICAGO (Cook)
Chicago State Hospital (2,814)
*Illinois State Psychiatric Institute (360)
DANVILLE (Vermilion)
*Veterans Administration Hospital (J-1,680)
DOWNEY (Lake)
*Veterans Administration Hospital (J-2,487)
EAST MOLINE (Rock Island)
*East Moline State Hospital (1,343)
ELGIN (Kane)
Elgin State Hospital (3,910)
GALESBURG (Knox)
*Galesburg State Research Hospital (1,843)
JACKSONVILLE (Morgan)
*Jacksonville State Hospital (2,002)
KANKAKEE (Kankakee)
*Kankakee State Hospital (2,493)
MANTENO (Kankakee)
Manteno State Hospital (5,841)
MENARD (Randolph)
Illinois Security Hospital (400)
PEORIA (Peoria)
*Peoria State Hospital (1,660)
TINLEY PARK (Cook)
Tinley Park State Hospital (480)

PRIVATE MENTAL HOSPITALS

AURORA (Kane)
*Mercyville Hospital (B-160)
CHICAGO (Cook)
*Fairview Hospital (C-100)
*Nicholas J. Pritzker Center (B-40)
*Pinel Hospital (B-70)
*Ridgeway Hospital (B-92)
DES PLAINES (Cook)
Forest Hospital (C-100)
ELGIN (Kane)
*Resthaven Hospital (C-100)
FOREST PARK (Cook)
*Riveredge (C-160)
WINNETKA (Cook)
*North Shore Hospital (C-100)

STATE SCHOOLS FOR MENTALLY DEFECTIVE

CENTRALIA (Marion)
Warren G. Murray Children's Center (558)
CHICAGO (Cook)
*Illinois State Pediatric Institute (264)
DIXON (Lee)
Dixon State School (3,336)
DWIGHT (Livingston)
William W. Fox Children's Center (250)
HARRISBURG (Saline)
A. L. Bowen Children's Center (240)
LINCOLN (Logan)
Lincoln State School (3,828)

Identification of Hospitals

*The hospitals marked with an asterisk (*) are those which are accredited by the Joint Commission on Accreditation of Hospitals as of Jan. 1, 1968.

The presence of a hospital on this list means it has complied in the main with the standards of the Joint Commission on Accreditation of Hospitals as compiled over the years by the medical and hospital professions. The standards are minimal and it is hoped hospitals will make every effort to exceed them.

Hospitals with less than 25 beds are not eligible for accreditation.

Accredited hospitals with a functioning utilization review plan are eligible providers of service under Medicare. Hospitals ineligible for accreditation or unable to meet JCAH requirements have been especially surveyed by the Illinois Department of Public Health and virtually all have been certified as eligible providers of service under Medicare.

Inquires about this listing or hospital accreditation should be directed to the office of the Joint Commission on Accreditation of Hospitals at 645 N. Michigan Ave., Chicago 60611.

**Double asterisk: approved to admit selected gynecological patients to maternity departments.

†Dagger indicates general hospitals having psychiatric units licensed by the Illinois Department of Public Health. All other mental facilities are licensed and/or operated by this department (federal hospitals excluded).

Number in parenthesis indicates number of beds in hospital. Initial preceding number refers to the type of control, as follows:

A—Corporation
B—Non-profit association or corporation
C—Privately owned and operated
D—City
E—County
F—Hospital District
G—Sanitarium District
H—Township
I—State
J—Federal

DIRECTORY OF LICENSED HOMES

The following list of homes licensed by the Illinois Department of Public Health (as of August, 1968) is divided into three sections: nursing homes, sheltered care homes, and homes for the aged. Ownership of these homes may be individual, partnership, corporation for profit, non-profit corporation, government, or trust-endowment.

A Nursing Home is equipped and staffed to provide personal and nursing care to all residents.

A Sheltered Care Home is equipped and staffed to provide only personal services such as assistance with meals, dressing, bathing, etc., but not nursing care.

A Home for the Aged is operated not-for-profit under religious or fraternal auspices or under an endowment. It is operated primarily for persons over 60 years of age and may provide personal care only or nursing and personal care. Some of these homes for the aged provide special services over and above nursing care.

Figure in parentheses indicates number of beds.

NURSING HOMES

ABINGDON (Knox County)
- Abingdon Nursing Home (74)
  W. Martin St.

ALBION (Edwards County)
- Rest Haven Manor (49)
  120 W. Main St.

ALEDO (Mercer County)
- Mercer County Nursing Home (62)
  Rt. 4
- Oakview Nursing Home (49)
  3rd Ave. and 12th St.
- Twilight Haven (14)
  303 E. Seventh St.

ALHAMBRA (Madison County)
- Haven of Rest (19)

ALTON (Madison County)
- College Avenue Nursing Home (19)
  920 College Ave.
- Eunice C. Smith Nursing Home (64)
  1251 College Ave.
- Main Street Nursing Home (40)
  1216 Main St.
- Riverview Nursing Home (23)
  440 Jefferson St.
- Villa Terrace Convalescent Home (26)
  510 Seminary Sq.
- Yinger Nursing and Convalescent Center, Inc. (55)
  2349 Virden Dr.

AMBOY (Lee County)
- Forman Nursing Home (18)
  339 N. Mason Ave.

ANNA (Union County)
- Union County Skilled Nursing Home (60)
  517 N. Main St.

ARCOLA (Douglas County)
- Fishel Nursing Home (26)
  129 N. Pine St.

ARLINGTON HEIGHTS (Cook County)
- Arlington Heights Rest Home (40)
  414 N. Vail St.

AROMA PARK (Kankakee County)
- Campbell Nursing Home (32)
  Fourth St.

ARROWSMITH (McLean County)
- DeArms Nursing Home (15)
  W. Crosson St.

ARTHUR (Moultrie County)
- The Arthur Home (42)
  423 Eberhardt Dr.

ATLANTA (Logan County)
- Atlanta Nursing Home (16)
  Chatham St.
- Bartmann Nursing Home (30)
  R. R. 1

AUBURN (Sangamon County)
- Parks Home (54)
  304 Maple St.

AUGUSTA (Hancock County)
- Augusta Nursing Home (18)
  E. Main St.

AURORA (Kane County)
- Aurora Borealis Nursing Center (112)
  1601 N. Farnsworth Ave.
- Colonial Nursing Home (19)
  422 N. Lake
- Elmwood Nursing Home (49)
  1017 W. Galena Blvd.

AVON (Warren County)
- Avon Nursing Home, Inc. (48)

BARRINGTON (Cook County)
- Barrington Rest Home, Inc. (50)
  145 W. Main St.

BARRY (Pike County)
- Barry Nursing Home (28)
  780 Grand St.
- Churchill Nursing Home (21)
  1038 Pratt St.

BATAVIA (Kane County)
- Kane County Home (99)
  Averill Rd.

BEARDSTOWN (Cass County)
- Boyd Nursing Home, Inc. (41)
  209-215 W. Third St.
- Brierly House Nursing Home, Inc. (34)
  604 State St.
- Elmwood Manor (49)
  13th & Grand Ave.
- Parkview Nursing Home (29)
  903 E. Third St.

BEAVERVILLE (Iroquois County)
- Haven of Rest Nursing Home (44)

BELLEVILLE (St. Clair County)
Atkinson Nursing Home (25)
514 S. Jackson St.
Herald Nursing Home (24)
506 Court St.
Hillcrest Convalescent Home (24)
420 Mascoutah Ave.
Memorial Nursing Home (111)
4315 Memorial Dr.
Rest Haven Old Folks Home (36)
44th St. and N. Belt West
St. Elizabeth's Home (72)
211 S. Third St.

BELLWOOD (Cook County)
Elizabeth Van Gehr Nursing Home (16)
209 S. 22nd Ave.

BELVIDERE (Boone County)
Maple Crest Nursing Home (48)
Boone County Home
R.R. 1, Rt. 76
Sutton's Nursing Home (34)
226 N. State St.

BEMENT (Piatt County)
Bement Rest Haven (27)
101 S. Sangamon St.

BENTON (Franklin County)
Franklin Hospital Skilled Nursing Care Unit (82)
201 Bailey Ln.
Linwood Nursing Home, Inc. (30)
N. Main and Mitchell Sts.
Rest Haven Nursing Home (28)
418 W. Webster

BERWYN (Cook County)
Fairfax Geriatric & Convalescent Center (106)
3601 S. Harlem Ave.
Pershing Convalescent Home (63)
3900 S. Oak Park Ave.
R. N. Convalescent Home (51)
6918 Windsor Ave.

BLANDINSVILLE (McDonough County)
Newland Nursing Home (42)
Van Buren and Breckenridge

BLOOMINGDALE (DuPage County)
Elaine Boyd Creche (98)
267 E. Lake St.
Mark Lund Hilltop, Inc. (65)
158 Prairie St.

BLOOMINGTON (McLean County)
Heritage Manor (99)
Walnut at Clinton Blvd.
Maple Grove Nursing Home (86)
S. Main Street Rd.
Nel-Dor Arms Nursing Home (32)
1116 E. Lafayette St.

BLUE ISLAND (Cook County)
Bel-Air Nursing Home (28)
2418 W. 127th St.
Blue Island Nursing Home (35)
2427 W. 127th St.
Burr Oaks Nursing & Convalescent Center (38)
2426 W. Burr Oaks Ave.

BLUFORD (Jefferson County)
Schumm Nursing Home (38)

BRADLEY (Kankakee County)
The Hallmark House (98)
700 N. Kinsie, Rt. 54

BROOKFIELD (Cook County)
Brookfield Nursing & Convalescent Home (21)
9128 W. 31st St.
Hill Haven Nursing Home (13)
4548 Deyo

BUNKER HILL (Macoupin County)
Tower View Nursing Home No. 1 (37)
403 Morgan St.

BURNHAM (Cook County)
The Homestead (96)
14500 Manistee Ave.

BUSHNELL (McDonough County)
The Elms (40)
McDonough County Home
Heron Nursing Home (30)
708 N. Dean St.

CAMP POINT (Adams County)
Grandview Manor, Inc. (49)
205 E. Spring St.

CANTON (Fulton County)
Canton Nursing Home, Inc. (33)
N. Main St.
Sherwood Nursing Home (31)
914 S. Main St.

CARBONDALE (Jackson County)
Styrest Nursing Home (104)
Rt. 4 on Tower Rd.

CARLINVILLE (Macoupin County)
Joiner Nursing Home (35)
706 N. Oak St.
Lake View Nursing Home (74)
R.R. 3
Lee Nursing Home (10)
334 Orient St.
Macoupin County Nursing Home (98)
R.R. 2
Scherba's Nursing Home (16)
817 N. High St.
Weatherford Nursing Home (85)
318 Buchanan St.
Woodlawn Acres Convalescent and Nursing Home (26)
W. Hard Rd., State Rt. 108

CARMI (White County)
White County Nursing Home (90)
R.R. 3
Wilmar Restorium, Inc. (85)
College Blvd.

CARROLLTON (Greene County)
Tower View Nursing Home No. 2 (26)
626 Maple Ave.

CASEY (Clark County)
Casey Nursing Home (92)
N. 10th St.
Rude's Goodwill Home (22)
208 W. Main St.
CASEYVILLE (St. Clair County)
Caseyville Nursing Home (31)
321 O'Fallon St.
CENTRALIA (Marion County)
Centralia Fireside House, Inc. (92)
1030 E. McCord St.
CHAMPAIGN (Champaign County)
American Manor Convalescent Home (26)
1002 W. Church St.
Greenbrier Manor (126)
1915 S. Mattis
Leonard Nursing Home, Inc. (21)
618 W. Church
Oliver Nursing Home (22)
1102 W. Church St.
CHARLESTON (Coles County)
Adkins Nursing Home (29)
849 C St.
Charleston Nursing Home (24)
216 Fifth St.
Hillcrest Nursing Home, Inc. (49)
635 Division St.
Hilltop Nursing Home, Inc. (72)
910 W. Polk St.
Oakwood Convalescent Home (28)
1041 Seventh St.
Rennel's Nursing Home (15)
214 Fifth St.
CHERRY VALLEY (Winnebago County)
Cherry Valley Rest Home (35)
Box 123
CHESTER (Randolph County)
Three Springs Lodge (63)
R.R. 1
CHICAGO (Cook County)
A-1 Nursing Home, Inc. (43)
4247 N. Hazel
A-1 Nursing Home, Inc. (8)
4249 N. Hazel
Addison Manor, Inc. (40)
3526 N. Reta Ave.
Albany Park Kosher Nursing Home, Inc. (30)
3418 W. Ainslie
All American Nursing Home (144)
5440-52 N. Broadway
Alshore House (53)
2840 Foster Ave.
Anna Hadley Nursing Home (29)
3209 W. Douglas Blvd.
Arthur W. Devermann Residence (16)
5746 N. Sheridan Rd.
Austin Congress Nursing Home (136)
901 S. Austin Blvd.
Beachview Convalescent Home, Inc. (47)
6345 N. Sheridan Rd.
Beacon Hill Nursing Home (33)
4530 N. Beacon St.
Beckwith Nursing Home (36)
3240 W. Washington Blvd.
Bell Nursing Home (28)
11079 S. Bell Ave.
Belmont Rest Home, Inc. (55)
1936 W. Belmont
Beverly Hills Nursing Home (32)
10347 Longwood Dr.
Birchwood Beach Convalescent Home No. 1 (39)
7350 N. Sheridan Rd.
Birchwood Beach Convalescent Home No. 2 (32)
7364 N. Sheridan Rd.
Byrn Mawr House, Inc. (183)
6141 N. Pulaski Rd.
Burke Nursing Home (10)
11840 S. Western Ave.
Burnside Rest Home (49)
9435 Langley Ave.
Carmen Manor (114)
1470 W. Carmen Ave.
Colonial Towers Nursing Home (30)
6032 Kenmore Ave. North
Davis Nursing Home, Inc. (85)
725-29 Waveland Ave.
Dearborn House, Inc. (128)
2400 S. Dearborn St.
Douglas Park Nursing Home (40)
1518-22 S. Albany Ave.
Doyle Nursing Convalescent Home (35)
9624-32 S. Vincinnes Ave.
Edgewater Manor (42)
5838 N. Sheridan Rd.
Elizabeth Olivia Home (49)
3952 S. Ellis Ave.
Elsa S. Long Convalescent Home (46)
5250-5256 N. Sheridan Rd.
Elston Home, Inc. (114)
4340 N. Keystone Ave.
Englewood Rest Haven, Inc. (26)
7253 Yale Ave.
Fargo Beach Home, Inc. (143)
7445 N. Sheridan Rd.
Farwell Beach Convalescent Home (27)
1145 W. Farwell Ave.
Feinstein's Rest Home, Inc. (27)
5960 N. Sheridan Rd.
Fountainebleau Manor, Inc. (60)
6318 N. Winthrop Ave.
Fox River Pavilion (74)
4700 N. Clarendon Ave.
Fullerton Convalescent Home, Inc. (132)
1400 W. Monroe St.
Garden View Home, Inc. (130)
6450 N. Ridge Ave.
Garfield Nursing Home (28)
3834 W. Washington Blvd.
Granville Manor (45)
1021 Granville Ave.
Hampden Manor (40)
2724 N. Hampton Ct.

Harmon-Bragg Nursing Home, Inc., No. 1 (25)
6455 S. Kimbark Ave.
Harmon-Bragg Nursing Home, Inc., No. 2 (36)
6463 S. Kimbark Ave.
Hastings Nursing Home (14)
7241 S. Princeton Ave.
Hearthside Nursing Home, Inc. (73)
1223 W. 87th St.
Hollywood Convalescent Home, Inc. (45)
1054 W. Hollywood Ave.
Howard Convalescent Home, Inc. (32)
6522 S. Harvard Ave.
Ivory Nursing Home, Inc. (39)
5839 S. Calumet Ave.
Johnson Nursing Home, Inc. (41)
3321 W. Fulton St.
Johnson Rehabilitation Nursing Home, Inc. (76)
3456 W. Franklin Blvd.
Kenmore House (109)
5517 N. Kenmore Ave.
Ken-Rose Rest Home (44)
6255 N. Kenmore Ave.
Kostner Manor (119)
1617 N. Kostner Ave.
Lake Shore Nursing Home, Inc. (27)
7230 N. Sheridan Rd.
Lakeside Nursing Home (24)
6330 N. Sheridan Rd.
Lake View Manor Rest Home (42)
2824 N. Sheridan Rd.
Lehrer Nursing Home, Inc. (40)
4636 N. Beacon St.
Lincoln Park Home (33)
2042 N. Orleans St.
Linderman Nursing Home, Inc. (25)
3311 W. Monroe St.
Malden Nursing Home, Inc. (26)
4616 N. Malden Ave.
Maple Nursing Home (10)
4743 W. Washington St.
Mark Howard Home (93)
4938 S. Drexel Blvd.
Martha Washington Manor, Inc. (99)
4515 S. Drexel Blvd.
Melbourne Convalescent Home (188)
4625 N. Racine Ave.
Midwest Rest Haven, Inc. (32)
310 S. Hamlin Ave.
Miller Nursing Home (46)
3256 W. Douglas Blvd.
Misericordia Home (136)
2916 W. 47th St.
Monterey Convalescent Home (56)
4616 S. Drexel Blvd.
Monterey Convalescent Home (62)
1919 S. Prairie Ave.
Montgomery Convalescent Home (80)
5956 S. Wabash Ave.
Mortkowicz Kosher Nursing Home (20)
4851 N. Rockwell Ave.
Mt. Pisgah Nursing Home (49)
4220-28 S. Champlain Ave.
Nesbitt Home (34)
943 W. Foster Ave.
North Shore Rest Haven, Inc. (49)
7428 N. Rogers Ave.
Ogden Park Convalescent Home (60)
6617-25 S. Racine Ave.
Panenka Nursing Home (25)
1901 S. Lawndale Ave.
Park House (86)
2320 S. Lawndale Ave.
Patterson Convalescent Home (32)
3242 W. Maypole Ave.
Pedraza Nursing Home, Inc. (31)
3230 W. Washington St.
Pedraza Nursing Home, Inc. (19)
3234 W. Washington St.
Peyton Convelascent Home (44)
4541 S. Michigan Ave.
Rabbi Meisels Convalescent Home, Inc. (49)
4900 N. Bernard Ave.
Ridge Manor Convalescent Home (35)
5888 N. Ridge Ave.
Rosewood Terrace Rest Home, Inc. (69)
6668 N. Damen Ave.
Royal Manor (28)
5640 N. Sheridan Rd.
St. Michael's Rest Haven, Inc. (43)
4815 S. Drexel Blvd.
Schiller Rest Home, Inc. (30)
1428 W. Jarvis
Sheridan Gardens Convalescent Home, Inc. (99)
1426 W. Birchwood Ave.
Shorecrest Convalescent Home, Inc. (35)
7331 N. Sheridan Rd.
Shore View Manor Convalescent Home, Inc. (31)
2719 E. 75th St.
South Shore Kosher Rest Home, Inc. (111)
7325 S. Exchange Ave.
South Shore Pavilion (113)
7750 South Shore Dr.
The Sovereign Home (55)
6159 N. Kenmore Ave.
Stern's Convalescent Home, Inc. (37)
730 Waveland St.
Stewart Nursing Home, Inc. (23)
6710 Stewart Ave.
Sunnyside Nursing Home (47)
4537 N. Greenview Ave.
Sunset Nursing Home, Inc. (192)
7270 South Shore Dr.
Thorndale Manor (41)
1020 W. Thorndale Ave.
Uptown Convalescent Home (55)
4646 N. Beacon St.
Vincinnes Manor, Inc. (305)
4724 Vincinnes Ave.
Wellington Plaza (91)

504 W. Wellington Ave.
Wendt Nursing Home (33)
5914 N. Sheridan Rd.
West Side Nursing Home, Inc. (36)
1900 S. Kedzie Ave.
Westwood Manor, Inc. (115)
2444 W. Touhy Ave.
Whitehall Convalescent and Nursing Home, Inc. (91)
1901 N. Lincoln Park West
Wincrest Nursing Home, Inc. (49)
6326 N. Winthrop Ave.
Winston Manor Convalescent and Nursing Home, Inc. (178)
2155 W. Pierce Ave.
Wrightwood Nursing Home, Inc. (90)
2732 Hampden Ct.

CHICAGO HEIGHTS (Cook County)
Bel-Air Nursing Home No. 2 (21)
309 W. 16th St.
Riviera Manor Nursing Home, Inc. (110)
490 W. 16th Pl.

CHILLICOTHE (Peoria County)
Parkhill Nursing Home (66)
P.O. Box 259

CLINTON (DeWitt County)
Crest View Nursing Home, Inc. (48)
U. S. Hwy. 51 N.
DeWitt County Nursing Home (42)
R.R. 1
Pine Crest Nursing Home (41)
North Center Limits

COAL VALLEY (Rock Island County)
Oak Glen Nursing Home (286)

COLCHESTER (McDonough County)
Helton Nursing Home (15)
East St.

COLLINSVILLE (Madison County)
Pleasant Rest Nursing Home (89)
614 Summit

CREAL SPRINGS (Williamson County)
Creal Springs Nursing Home (45)
S. Line St.

CRESTWOOD (Cook County)
Rest Haven Illiana Christian Convalescent Home, Inc. (99)
13259 S. Central Ave., (P.O. Palos Heights)

CRETE (Will County)
Skylane Acres (10)
Rt. 1, Box 359-20

DANVILLE (Vermilion County)
Colonial Manor, Inc. (55)
629 Warrington Ave.
Danville Care, Inc. (98)
1701 N. Bowman Ave.
Danville Care, Inc. North (72)
1715 N. Bowman Ave.
Margenette (31)
503 W. North St.
Nance Nursing Home (14)
622 Bryan Ave.
Vermilion County Nursing Home (191)
R.R. 1, Box 13

DECATUR (Macon County)
American Nursing Center of Decatur (95)
444 W. Harrison St.
Lakeshore Manor (77)
1293 S. 34th St.
Mabel's Nursing Home (29)
820 W. North St.
Macon County Tuberculosis Sanitorium & Nursing Home (34)
400 W. Hay
Mary Ann's (28)
640 W. Main St.
Muirheid Nursing Home (20)
231 E. Condit St.
Muirheid's Nightingale Manor (21)
805 E. Johns Ave.
Strong's Nursing Home (18)
936 N. Church St.
Wakefield Aged Retreat Home (22)
1504 N. Water St.
Wakefield Rest Home (26)
800 W. McKinley Ave.
West View Nursing Home (19)
628 W. Main St.

DeKALB (DeKalb County)
DeKalb County Nursing Home (136)
Sycamore Rd., R.R. 23
Pine Acres Retirement Center (60)
1212 S. Second St.

DESPLAINES (Cook County)
Brookwood Convalescent Center, Inc. (111)
Lyman and Dempster Sts.
Des Plaines Convalescent Home (28)
866 Lee St.
Golf Road Pavilion (142)
9555 W. Golf Rd.
Graceland Home of DesPlaines, Inc. (41)
545 Graceland Ave.

DIXMOOR (Cook County)
Starnes Nursing Home (39)
14434 S. Hoyne Ave.

DIXON (Lee County)
Lee County Nursing Home (84)
R.R. 4
Orchard Glen, Inc. (58)
141 N. Court St.

DOLTON (Cook County)
Sandra Memorial Nursing and Convalescent Home (61)
14325 S. Blackstone Ave.

DOWNER'S GROVE (DuPage County)
Highland House Nursing Home, Inc. (62)
35th St. and Highland Ave.

DUNDEE (Kane County)
Bowes Nursing Home (49)
305 Oregon St.
Gregg Nursing Home (31)
417 E. Hill St.

DUQUOIN (Perry County)
Fair Acres Nursing Home (76)
Jackson and Madison Sts.

DURAND (Winnebago County)
Medina Nursing Center (66)
P.O. Box 538
EAST ST. LOUIS (St. Clair County)
Carr Nursing Home (47)
3110 Bond Ave.
Fletcher Ann Convalescent Home (38)
2640 St. Louis Ave.
Lively Nursing Home (32)
1303 Baugh Ave.
EDWARDSVILLE (Madison County)
Anna-Henry Nursing Home (84)
637 Hillsboro
Madison County Nursing Home (59)
Main St.
EFFINGHAM (Effingham County)
Marks Nursing Home (20)
406 E. Jefferson
Rollin Hills Rest Home (96)
Rollin Hills Subdivision
ELDORADO (Saline County)
Eldorado Nursing Home, Inc. (49)
Third and Locust Sts.
Good Shepherd Nursing Home No. 1 (61)
First and Jasper Sts.
ELGIN (Cook County)
Little Angels (45)
Rt. 3, Box 201A, Rt. 58
ELGIN (Kane County)
Daybreak Home (27)
420 Douglas Ave.
Elgin-Bowes Nursing Home (49)
105 N. Gifford St.
Hillcrest Convalescent Home, Inc. (26)
4 N. Jackson St.
Isabelle Home (18)
104 S. State St.
Mary Margaret Manor (94)
134 N. McLean Blvd.
Oliver Nursing Home, Inc. (25)
325 Watch St.
Raloff Nursing Home (10)
316 Division St.
Simpson House, Ltd. (67)
170 S. State St.
ELMHURST (DuPage County)
Elmhurst Nursing Home (42)
200 E. Lake St.
ELMWOOD (Peoria County)
Elm Haven, Inc. (75)
EL PASO (Woodford County)
Lewis Nursing Home, Inc. (17)
487 Elmwood Ct.
McDaniel Nursing Home (33)
404 E. First St.
EVANSTON (Cook County)
Broad Nursing Home (25)
2001 Orrington Ave.
Broad Nursing Home (23)
1840 Asbury Ave.
Dobson Plaza, Inc. (52)
120 Dodge Ave.
Evanston Convalescent Center, Inc. (65)
1300 Oak Ave.
Klingler Nursing Home (5)
2306 Ridge Ave.
Pembridge House, Inc. (96)
1406 Chicago Ave.
Ridge Crest Home (21)
1708 Ridge Ave.
Three Oaks Nursing Center (124)
500 Asbury Ave.
EVERGREEN PARK (Cook County)
Bel Air Nursing Home (20)
9307 S. Crawford Ave.
Evergreen Gardens, Inc. (162)
9125 S. Crawford Ave.
Evergreen Manor Nursing Home (22)
3327 W. 95th St.
Gunderson's Convalescent & Nursing Home (17)
2701 W. 95th St.
Peace Memorial Home (160)
10124 S. Kedzie Ave.
FAIRBURY (Livingston County)
Helen Lewis Smith Pavilion (23)
519 S. Sixth St.
FARMER CITY (DeWitt County)
Farmer City Nursing Home, Inc. (22)
326 Clinton Ave.
Jackson Heights Nursing Home (49)
Brookview Dr. and Crabtree Ct.
FLORA (Clay County)
Raber Nursing Home (28)
402 E. Fourth St.
FREEBURG (St. Clair County)
Marian Nursing Home (17)
406 State St.
FREEPORT (Stephenson County)
Benjamin Stephenson Nursing Home (56)
Walnut Rd.
Crestview Manor, Inc. (42)
565 N. Turner Ave.
Van Buren Nursing Home (20)
503 N. Van Buren
FULTON (Whiteside County)
Harbor Crest Home, Inc. (49)
810 E. 17th St.
GALATIA (Saline County)
Good Shepherd Nursing Home No. 2 (45)
Main and Cross Sts.
GALENA (Jo Daviess County)
Sunny Hill Nursing Home (32)
513 Bouthillier St.
GALESBURG (Knox County)
Americana Nursing Center of Galesburg (67)
270 E. Losey at Kellogg
Campbell Nursing Home (16)
731 N. Seminary
Harvey Nursing Home (19)
774 N. Broad St.
Powell Nursing Home (17)
620 S. Academy
Schrader Nursing Home (17)

490 N. Cherry
GENESEO (Henry County)
Wright Nursing Home (28)
426 W. First St.
Henry County Convalescent Home (126)
R.R. 4
GENEVA (Kane County)
Anna Baum Home (36)
115 Campbell St.
GENOA (DeKalb County)
Villa Nursing Home (30)
121 Main St.
GIBSON CITY (Ford County)
Gibson Community Hospital Annex (40)
430 E. 19th St.
Gibson Manor, Inc. (47)
525 Hazel Dr.
GILLESPIE (Macoupin County)
Tower View Nursing Home No. 3 (8)
703 S. Second St.
GLEN ELLYN (DuPage County)
Manor Convalescent Home, Inc. (49)
818 DuPage Rd.
GLENVIEW (Cook County)
Golf Mill Nursing Home, Inc. (37)
77 Greenwood Ave.
Whitehaven Acres, Inc. (32)
Greenwood Ave. and Melody Ln.
GODFREY (Madison County)
Blu-Fountain Manor, Inc. (75)
Rt. 100
GRANITE CITY (Madison County)
The Colonnades (82)
1 Colonial Dr.
GRAYVILLE (White County)
Baldwin Nursing Home, Inc. (54)
305 W. North St.
GREENFIELD (Greene County)
Cedar Knoll Nursing and Convalescent Home(29)
711 Bluff St.
GREENVILLE (Bond County)
Bourgeois Nursing Home, Inc. (32)
100 W. College St.
GRIDLEY (McLean County)
Dowell Nursing Home (21)
202 W. Sixth St.
HAMPSHIRE (Kane County)
Hampshire Nursing Home (64)
Jackson and Warner Sts.
Lydia Nursing Home (20)
25 W. Jackson St.
HARDIN (Calhoun County)
Sunrise Nursing Home (20)
R.R. 2
HARRISBURG (Saline County)
Bacon's Nursing Home, Inc. (21)
Box 269, N. Granger St.
Country Club Manor (68)
1000 W. Sloan
HARVARD (McHenry County)
Harvard Rest Home (44)
210 E. Front St.
HARVEY (Cook County)
Heather Manor Convalescent Center (49)
15600 S. Honore Ave.
HAVANA (Mason County)
Havana Nursing Home (43)
224 W. Mound St.
Reid Nursing Home, Inc. (36)
121 S. Orange St.
HERRIN (Williamson County)
Hampton Nursing Home (30)
321 S. 14th St.
Mattingly Nursing Home, Inc. (34)
920 S. 14th St.
HICKORY HILLS (Cook County)
Villa Marie Nursing Home, Inc. (78)
9246 S. Roberts Rd., (P.O. Oak Lawn)
HIGHLAND (Madison County)
Helvetia Nursing Home (49)
2510 Lemon Street Rd.
Miles Nursing Home (26)
817 Ninth St.
HIGHLAND PARK (Lake County)
Abbott House (65)
405 Central Ave.
HIGHWOOD (Lake County)
Pavilion of Highland Park (59)
50 Pleasant Ave.
HILLSBORO (Montgomery County)
Hillsboro Nursing Home (51)
624 S. Main St.
HILLSIDE (Cook County)
Oakridge Convalescent Home (42)
323 Oakridge Ave.
HINSDALE (DuPage County)
Oaks Nursing Home (49)
Rt. 83 and 91st St.
Shank Rest Home (31)
525 W. Ogden Ave.
HOPEDALE (Tazewell County)
Hopedale Nursing Home (86)
Second St.
INA (Jefferson County)
Underwood Nursing Home (15)
3 Elm St.
IRVING (Montgomery County)
Rest Haven, Inc. (30)
JACKSONVILLE (Morgan County)
Lasley Nursing Home (20)
844 W. College Ave.
Meline Nursing Center (90)
1024 W. Walnut St.
Modern Care Convalescent and Nursing Home (40)
1500 W. Walnut St.
JERSEYVILLE (Jersey County)
Garnet Nursing Home (37)
602 W. Pearl St.
Green Lawn Nursing Home (35)
518 S. State St.
Waters Nursing Home (21)
408 N. Giddings St.

JOLIET (Will County)
Americana Nursing Center of Joliet (92)
300 N. Madison
Broadway Nursing Home (70)
216 N. Broadway
LeSan Nursing Home (25)
601 Campbell St.
Lincoln Nursing Home (86)
611 E. Cass St.
Pleasant Center Nursing Home (38)
5 S. Center St.
Sunny Hill Nursing Home (41)
501 Ella Ave.
KANKAKEE (Kankakee County)
Americana Nursing Center of Kankakee (92)
900 W. River Pl.
Casper Nursing Home (30)
480 E. Oak St.
Deerwood Convalescent Home (57)
R.R. 5, Aroma Park Rd.
KEWANEE (Henry County)
Spoon River Residence (41)
401 Pine St.
KNOXVILLE (Knox County)
Good Samaritan Nursing Home (49)
407 N. Hebart St.
Knox County Nursing Home (150)
219 N. Market St.
St. Martha's Nursing Home, Inc. (46)
N. Market St.
LACON (Marshall County)
St. Joseph's Nursing Home (54)
401 Ninth St.
LaGRANGE (Cook County)
LaGrange Colonial Manor Convalescent and Nursing Center (179)
339 N. Ninth Ave.
LaGrange Convalescent and Nursing Center (58)
42 S. Ashland Ave.
LAKE BLUFF (Lake County)
Hill Top Farm (14)
502 N. Waukegan Rd.
LAKE VILLA (Lake County)
Hampstead House (28)
601 S. Rt. 59
Lake Villa Nursing Home (30)
201 Cedar Ave.
Venetian Manor Convalescent Home (30)
1913 E. Grand Ave., Lindenhurst Addition
LAKE ZURICH (Lake County)
Bee Dozier's Maple Hill Nursing Home, Inc. (86)
P.O. Box 288
LANSING (Cook County)
Tri-State Manor Nursing Home (56)
2500—175th St.
LAWRENCEVILLE (Lawrence County)
Shidler Nursing Home (22)
1022 Twelfth St.
LEBANON (St. Clair County)
Bohannon Nursing Home, Inc. (24)
404 S. Fritz St.
LENA (Stephenson County)
Ortiz Convalescent Home (33)
516 Schuyler St.
LEWISTOWN (Fulton County)
Clarytona Manor, Inc. (96)
Sycamore Dr.
Stephens Nursing Home (23)
305 S. Main St.
LEXINGTON (McLean County)
Three Oaks Nursing Home (48)
301 S. Vine St.
LIBERTYVILLE (Lake County)
Lake County Nursing Home (153)
1125 N. Milwaukee Ave.
Magnus Rest Home (25)
1206 S. Milwaukee Ave.
LINCOLN (Logan County)
Abraham Lincoln Memorial Extended Care (53)
315 Eighth St.
Christian Nursing Home (48)
1507 Seventh St.
Mary Henry Nursing Home (52)
1800 Fifth St.
Wasson Nursing Home (19)
1011 Third St.
LITCHFIELD (Montgomery County)
Friendly Haven Nursing Home (28)
823 Chapin St.
Litchfield Nursing Home (48)
628 S. Illinois St.
LOUISVILLE (Clay County)
Hill Crest Nursing Home (40)
Chestnut St.
LOVES PARK (Winnebago County)
Fountain Terrace (49)
6131 N. 2nd St.
MACOMB (McDonough County)
Americana Nursing Center of Macomb (58)
120 Doctors Ln.
MARENGO (McHenry County)
Florence Nursing Home (46)
546 E. Grant Hwy.
MARION (Williamson County)
Fountains Nursing Home (68)
1301 E. DeYoung St.
MAROA (Macon County)
Villa Maria Nursing Home (14)
125 S. Main St.
MARSHALL (Clark County)
Burnsides Nursing Home, Inc. (90)
N. Second St.
MASCOUTAH (St. Clair County)
Grange Nursing Home (29)
Tenth St. (R.R. 1, Box 145)
Mascoutah Nursing Home (22)
213 E. Church St.
West Main Nursing Home (16)
1244 W. Main St.
MASON CITY (Mason County)
Christian Care Nursing Home (21)
705 E. Chestnut St.

MATTOON (Coles County)
Cunningham Nursing Home (31)
1312 Wabash Ave.
Douglas Nursing Center (49)
State Hwy. #121 West
MAYWOOD (Cook County)
Lendino Nursing Home, Inc. (14)
1110 S. Ninth Ave.
McHENRY (McHenry County)
Villa Nursing Home (68)
1201 W. Rocky Beach
McLEANSBORO (Hamilton County)
McLeansboro Nursing Home (37)
205 E. Cherry St.
MENDOTA (LaSalle County)
Sunrise Nursing Home (49)
1201 First Ave.
METROPOLIS (Massac County)
Metropolis Good Samaritan Home (48)
Box 145
MIDLOTHIAN (Cook County)
Bowman Nursing Home, Inc. (44)
14731 S. Turner Ave.
Bowman Nursing Home, Inc., No. 1 (49)
3249 W. 147th St.
Clover Acres (49)
5252 W. 147th St.
Largent's Convalescent Home (69)
4323 W. 147th St.
Maple Farms Convalescent Home (44)
147th & Long Ave.
MILAN (Rock Island County)
Comfort Harbor Nursing Home (39)
114 W. Second Ave.
MINONK (Woodford County)
Minonk Manor, Inc. (48)
201 Locust St.
MOLINE (Rock Island County)
Americana Nursing Center of Moline (67)
833 Sixteenth St.
Fairhaven Nursing Home (28)
2525 Ninth Ave.
MONMOUTH (Warren County)
Colonial Nursing Home, Inc. (23)
303 E. Broadway
Monmouth Nursing Home (28)
116 South H Street
Warren County Nursing Home (39)
R.R. 4
MONTICELLO (Piatt County)
Cozy Haven (10)
713 W. Bond St.
Piatt County Nursing Home (32)
R.R. 2
MORRIS (Grundy County)
Morris-Lincoln Nursing Home (87)
916 Fremont Ave.
Grundy County Nursing Home (49)
R.R. 4
MORRISON (Whiteside County)
Eveningside Nursing Home (23)
509 N. Genesee St.
MORRISONVILLE (Christian County)
Memorial Nursing Home (47)
200 W. Fifth St.
MORTON (Tazewell County)
Restmor, Inc. (78)
925 E. Jefferson
MT. CARMEL (Wabash County)
Monticello Nursing Home, Inc. (97)
Box 229
Wabash Nursing Home (30)
R.R. 3
MT. STERLING (Brown County)
Barker's Nursing Home (15)
204-206 Railroad Ave.
Haley's Nursing Home (10)
401 W. Main St.
Whited Nursing Home (20)
308 N. Capital St.
MT. VERNON (Jefferson County)
Hickory Grove Manor (111)
8 Doctors Park Rd.
Lowry's Nursing Home (27)
1304 Main St.
Setzekorn Nursing Home (31)
1300 Broadway
MT. ZION (Macon County)
Woodland, Inc., Nursing Home (70)
MUNDELEIN (Lake County)
North Riverwood Manor, Inc. (65)
Rt. 1, 106 Milwaukee Ave., (P.O. Half Day)
Pine Manor (27)
Rt. 1, Box 185
MURPHYSBORO (Jackson County)
Jackson County Nursing Home (158)
1441 N. 14th St.
Tyler Nursing Home, Inc. (69)
1711 Spruce St.
NAPERVILLE (DuPage County)
American Nursing Center of Naperville (97)
200 Martin Dr.
Brentwood Nursing Home (29)
1136 Mill St.
NASHVILLE (Washington County)
Friendship Manor, Inc. (125)
Friendship Dr.
NEWTON (Jasper County)
Newton Rest Haven (92)
300 S. Scott St.
NILES (Cook County)
Gross Point Manor (99)
6601 Touhy Ave.
Pleasantview Convalescent and Nursing Center, Inc. (91)
6840 W. Touhy Ave.
Svithiod Nursing Home (23)
8800 Grace St.
NORMAL (McLean County)
Americana Nursing Center of Bloomington-Normal (88)
510 Broadway
Brokaw Home (46)
Virginia and Franklin Sts.

NORTHBROOK (Cook County)
Eden View Convalescent and Geriatric Center (142)
222 Frontage Rd.
Northbrook Nursing Home & Rehabilitation Center, Inc. (149)
270 Skokie Rd.
OAK LAWN (Cook County)
Concord Nursing Home (91)
9401 Ridgeland Ave.
Doyle Nursing and Convalescent Homes, Inc. (92)
5432 W. 87th St.
Monticello Convalescent Center (99)
6300 W. 95th St.
Oak Lawn Convalescent and Geriatric Home (95)
9525 S. Mayfield
Parkside Gardens Nursing Home (77)
5701 W. 79th St.
OAK PARK (Cook County)
Oak Park Nursing Home, Inc. (41)
637 S. Maple Ave.
Patterson Nursing & Rehabilitation Care (22)
130 N. Austin Blvd.
Royal Oak Convalescent and Geriatric Center (204)
625 N. Harlem Ave.
The Woodbine (59)
6909 W. North Ave.
ODIN (Marion County)
Wutzler Nursing Home (29)
Kirkwood St.
Yaw Nursing Home (61)
Laury St.
O'FALLON (St. Clair County)
Parkview Colonial Manor (107)
300 Weber Dr.
OKAWVILLE (Washington County)
Washington Springs Nursing Home (130)
OLNEY (Richland County)
Burgin Nursing Home No. 1 (31)
305 S. Washington St.
Burgin Nursing Home No. 2 (29)
607 S. Elliott St.
Burgin Nursing Manor (75)
928 E. Scott St.
Golden Years Nursing Home (34)
502 S. Fair St.
Marks Nursing Home (28)
217 N. Fair St.
ORANGEVILLE (Stephenson County)
Krug Convalescent Home (13)
High St.
OTTAWA (LaSalle County)
Hassley's Health Haven (16)
Gentleman Rd., R.R. 4
Highland Sanatorium and Convalescent Home of LaSalle County (63)
800 Center St.
LaSalle County Home (68)
R.F.D. 1
Susie H. Moore Rest and Healing Home (13)
627 Third Ave.
PALATINE (Cook County)
Bee Dozier's Palatine Nursing Home (40)
W. Dundee Rd.
Plum Grove Nursing Home, Inc. (48)
24 S. Plum Grove Ave.
PALOS HILLS (Cook County)
Palos Hills Convalescent Center (130)
10426 S. Roberts Rd.
PANA (Christian County)
DePaepe-Ashcraft Nursing Home (83)
10 Oak St.
PARK RIDGE (Cook County)
Park Ridge Terrace (56)
665 Busse Hwy.
PAXTON (Ford County)
Ford County Nursing Home (74)
R.R. 2
Lyons Nursing Home (21)
440 E. Pells St.
PEKIN (Tazewell County)
Floy's Nursing Home (24)
803 Park Ave.
Knollcrest Nursing Home (49)
Allentown Rd.
PEORIA (Peoria County)
Americana Nursing Center of Peoria (65)
5600 Glen Elm Dr.
Baker Nursing Home (28)
500-502 W. Second St.
Bel-Wood Nursing Home (237)
7023 W. Planck Rd.
High View Nursing Home (68)
2308 W. Nebraska St.
Mahoney Nursing Home No. 1 (28)
444 W. Second St.
Mahoney Nursing Home No. 2 (19)
2149 N. Knoxville St.
Walker Nursing Home (16)
1504 W. Garden St.
PEORIA HEIGHTS (Peoria County)
Fireside House, Inc. (108)
1629 Gardner Ln.
Galena Park Home (24)
5533 N. Galena Rd.
PERU (LaSalle County)
Heritage Manor (59)
22nd and Rock Sts.
Tri City Nursing Home (21)
2804 Sixth St.
PETERSBURG (Menard County)
Menard Convalescent Center, Inc. (54)
Seventh and Antle Sts.
Sunny Acres (49)
Rt. 3
PITTSFIELD (Pike County)
Couch Nursing Home (35)
521 E. Washington St.
Pittsfield Nursing Home (74)
R.R. 3

PLYMOUTH (Hancock County)
Myrtle Sapp's Nursing Home (22)
Main St.
PONTIAC (Livingston County)
Livingston County Nursing Home (94)
R.R. 1
PRAIRIE CITY (McDonough County)
Westfall K & C. Nursing Home (9)
Reed and Union Sts.
Westfall Nursing Home (22)
Madison and Union Sts.
PRINCETON (Bureau County)
Prairie View Nursing Home (149)
R.R. 5
QUINCY (Adams County)
Eloise Nursing Home (13)
1614 N. Fourth St.
Hall Nursing Home (23)
1870 Vermont St.
Lincoln-Terrace Nursing Home, Inc. (92)
1315 N. Eighth St.
St. Joseph Hall (72)
1415 Vermont St.
Theda Boll Nursing Home (14)
438 N. Twelfth St.
RAYMOND (Montgomery County)
Cottage Nursing Home (33)
W. Sparks St.
ROANOKE (Woodford County)
Roanoke Manor, Inc. (79)
1102 W. Randolph St.
ROBBINS (Cook County)
Esma A. Wright Convalescent Center (206)
139th St. at Lydia
ROBINSON (Crawford County)
Gowen Nursing Home (49)
902 Mefford St.
Robinson Nursing Home (44)
503 E. Main St.
ROCHELLE (Ogle County)
Americana Nursing Center of Rochelle (49)
900 N. Third St.
ROCK FALLS (Whiteside County)
Colonial Acres Rest Home (55)
Rt. 2, Dixon Rd.
ROCKFORD (Winnebago County)
Alma Nelson Manor (174)
550 S. Mulford Rd.
Americana Nursing Center of Rockford (114)
2313 N. Rockton
Deacon Home (17)
611 N. Court St.
Johnson's Hill Top Nursing Home (16)
728 N. Court St.
Lund Nursing Home (17)
1503 Fourth Ave.
North Rockford Convalescent Home (49)
1925 Fremont St.
The Restorium (41)
2800 S. Main St.
River Bluff Nursing Home (204)
N. Main Rd.
River Manor, Inc. (108)
707 W. Riverside Blvd.
Rockford Municipal Sanitarium Nursing Home (59)
1601 Parkview Ave.
ROCK ISLAND (Rock Island County)
Mrs. Carroll's Nursing Home (26)
4434 Seventh Ave.
Parkway Rest Home (22)
557—30th St.
Shady Lawn Nursing Home, Inc. (29)
1018 Twelfth St.
ROSEVILLE (Warren County)
Roseville Nursing Home (18)
N. Main St.
ROSSVILLE (Vermilion County)
Hedrecka Nursing Home (32)
R.R. 2
ROUND GROVE (Whiteside County)
Whiteside County Nursing Home (75)
RUSHVILLE (Schuyler County)
Hills Convalescent Home (20)
717 E. Adams
Snyder's Home (49)
135 Morgan St.
RUTLAND (LaSalle County)
Rutland Nursing Home, Inc. (27)
E. Front St. and Chestnut St.
ST. ELMO (Fayette County)
Elm Haven Nursing Home (24)
317 Cumberland Rd.
ST. CHARLES (Kane County)
Valley Rest Home (24)
309 S. Sixth Ave.
SANDWICH (DeKalb County)
Sandhaven, Inc. (37)
517 N. Main St.
SALEM (Marion County)
Twin Willows Nursing Center (72)
Rt. 37 North
SAYBROOK (McLean County)
Kinsell's Nursing Home, Inc. (16)
205 N. Main St.
SHANNON (Carroll County)
Johnson's Nursing Home (59)
418 Ridge St.
SHAWNEETOWN (Gallatin County)
Loretta Nursing Home (61)
Logan and Lincoln Sts.
SHELBYVILLE (Shelby County)
Young's Shelbyville Restorium, Inc. (110)
Rt. 128 North
SHELDON (Iroquois County)
Happy Siesta (40)
220 E. Center St.
SIDELL (Vermilion County)
Fairview Alliance Home, Inc. (37)
R.R. 1
SILVIS (Rock Island County)
Happy Haven Rest Home (49)
118 Tenth St.

SKOKIE (Cook County)
Old Orchard Manor (61)
4660 Old Orchard Rd.
Skokie Valley Manor, Inc. (115)
4600 W. Simpson St.
Village Nursing Home in Skokie, Inc. (128)
9000 Lavergne Ave.
SMITHBORO (Bond County)
American Nursing Home (28)
SOUTH CHICAGO HEIGHTS (Cook County)
Suburban Convalescent Center (99)
120 W. 26th St.
SOUTH HOLLAND (Cook County)
Colonial Convalescent Home (65)
549 E. 162nd St.
SPARTA (Randolph County)
Randolph County Nursing Home (158)
W. Belmont
SPRINGFIELD (Sangamon County)
Americana Nursing Center of Springfield (116)
707 N. Rutledge
Carver Convalescent Home (61)
1527 E. Washington St.
Claudia's Nursing Home (51)
409 N. Grand Ave. East
Colonial Cottage (4)
116 S. State St.
Edwards Manor Nursing Home, Inc. (60)
1625 E. Edwards St.
Everett McKinley Dirksen House (152)
555 W. Carpenter
Hamilton Nursing Home (24)
925 N. Fifth St.
Haven Nursing Home (72)
2301 W. Monroe
Homestead Convalescent Home and Nursing Residence (60)
127 N. Douglas Ave.
Myrick Nursing Home (31)
925 S. Seventh St.
Phillips Nursing Home, Inc. (51)
630 N. Sixth St.
Ramshaw Retirement Home No. 1 (47)
631 N. Sixth St.
Ramshaw Retirement Home No. 2 (44)
611 N. Sixth St.
Ridgewood Nursing Home (48)
3400 Peoria Rd.
Rutledge Manor Care Home, Inc. (121)
819 N. Rutledge
Standage Nursing Home (25)
2205 E. Capitol Ave.
STAUNTON (Macoupin County)
Staunton Nursing Home, Inc. (36)
215 W. Pennsylvania St.
STERLING (Whiteside County)
Colonial Acres Rest Home (70)
Rt. 2
STOCKTON (Jo Daviess County)
Morgan Memorial Home (27)
501 E. Front Ave.
STREATOR (LaSalle County)
Edgetown Nursing Home (24)
West Chicago St.
Heritage Manor (57)
1525 E. Main St.
Star Haven Convalescent and Nursing Home (21)
405 N. Wasson St.
SULLIVAN (Moultrie County)
East View Manor Nursing Home (52)
Eastview Pl., Box 234
Singiser Nursing Home (30)
817 E. Jackson St.
SUMNER (Lawrence County)
Red Hills Rest Haven (96)
Pine Lawn Addition
SWANSEA (St. Clair County)
Castle Haven Convalescent Center (154)
225 Castellano Dr.
TAYLORVILLE (Christian County)
Dexheimer Nursing Home (21)
216 E. Franklin St.
Johnson Nursing Home (12)
1024 W. Park
Meadow Manor, Inc. (56)
Rt. 48 North
Smith's Guest Home (40)
305 E. Adams St.
TINLEY PARK (Cook County)
Kosary Nursing Home (73)
6660 W. 147th St.
McAllister Nursing Home No. 2 (45)
183rd and LaVerne Ave.
TOULON (Stark County)
Public Nursing Home (18)
219 S. Franklin St.
TREMONT (Tazewell County)
Tazewell County Nursing Home (125)
R.R. 1
TROY (Madison County)
Rockwood Rest Home (23)
212 N. Powell St.
TUSCOLA (Douglas County)
Martin Nursing Home (30)
114 E. Daggy St.
URBANA (Champaign County)
Americana Nursing Center of Champaign-Urbana (100)
600 N. Coler
Champaign County Nursing Home (198)
1701 E. Main St.
Fontana Nursing Care Center (40)
907 Lincoln Ave.
Hubert Nursing Home (19)
505 W. Green St.
VANDALIA (Fayette County)
Fayette County Hospital Annex (33)
727 W. Jackson
Fayette County Nursing Home (34)
R.R. 3
Ted Mangner Nursing Home, Inc. (31)
117 S. Seventh St.

VIENNA (Johnson County)
Hill View (51)
VILLA PARK (DuPage County)
Acre View Nursing Home (38)
538 S. Villa Ave.
VIRDEN (Macoupin County)
Miller's Nursing Home (23)
231 E. Deane St.
VIRGINIA (Cass County)
Kirkpatrick Nursing Home (24)
145 N. Front St.
Walker Nursing Home (30)
530 E. Beardstown St.
WARREN (Jo Daviess County)
Daters Nursing Home (18)
Water St.
Lahey Nursing Home (23)
Burnett St.
Sunnyside Nursing Home (15)
206 Lions St.
WASHBURN (Woodford County)
Washburn Nursing Home (32)
231 Parkside Dr.
WASHINGTON (Tazewell County)
Washington Home (36)
104 E. Holland St.
Washington Nursing Center (88)
1110 New Castle Rd.
WATERLOO (Monroe County)
Monroe County Nursing Home (178)
Illinois Ave.
WATSEKA (Iroquois County)
Iroquois Resident Home (58)
830 S. Fourth St.
WAUKEGAN (Lake County)
The Terrace Nursing Home (112)
1615 Sunset Ave.
Waukegan Pavilion Nursing Home, Inc. (96)
2217 W. Washington St.
WAVERLY (Morgan County)
Bridges Nursing Home (18)
200 E. State St.
WENONA (Marshall County)
Wenona Rest Haven, Inc. (31)
Elm St.
WEST CHICAGO (DuPage County)
Hazelhurst Nursing Home, Inc. (29)
Roosevelt Rd. and Gary Mill
Morton Manor Health Home (28)
R.R. 1, Box 753
WHEATON (DuPage County)
DuPage Convalescent Home (288)
O. S. 262 County Farm Rd.
Parkway Terrace Nursing Home (69)
205 E. Parkway Dr.
Wheaton Health Resort, Inc. (96)
1325 Manchester Rd.
WHITE HALL (Greene County)
Hill Top Haven (39)
McCarthy Ave. and U.S. Rt. 67A
WINFIELD (DuPage County)
Abbey Winfield Geriatric & Convalescent Home (48)
Wynwood Rd. and Shady Way
Zace Retirement Home (41)
27 W. 141 Liberty St.
WITT (Montgomery County)
Laura Charles Nursing Home, Inc. (37)
Allen St.
WOOD DALE (DuPage County)
Wood Dale Nursing Home (70)
140 N. Hemlock
WOODSTOCK (McHenry County)
Birchwood Nursing Home (13)
R.R. 1
New Woodstock Residence (112)
309 McHenry Ave.
Valley Hi Nursing Home (61)
2406 Hartland Rd.
Windgate (32)
11023 Rt. 14
YORKVILLE (Kendall County)
Hillside Nursing and Convalescent Home, Inc. (33)
Rt. 34 and Game Farm Rd.
Hillside Nursing and Convalescent Home, Inc., No. 2 (35)
Rt. 34 and Prairie Ln.
ZION (Lake County)
Golden Day Nursing Home (32)
923 Shiloh Blvd.
Parkview Nursing Home, Ltd. (70)
1911—27th St.
Zion Nursing Home (144)
2561 Sheridan Rd.

SHELTERED CARE HOMES

ALEDO (Mercer County)
Fortner Sheltered Care Home (36)
1006 E. Fifth St.
ALTON (Madison County)
Alby Street Sheltered Care Home (30)
1912 Alby St.
Burt Sheltered Care Home (29)
1414 Milton Rd.
Mitchell Sheltered Care Home (5)
1800 Belle St.
West Shelter Care Home (23)
1914 Washington Ave.
ANNA (Union County)
Dodson Shelter Care Home (18)
300 South St.
Galbraith Shelter Care Home (17)
223 W. Vienna St.
HS&D Sheltered Care Home (12)
201 E. Highland St.
Pitts Sheltered Care Home (19)
310 E. Davie St.
Walnut Grove Shelter Care (15)
612 E. Davie St.

ARROWSMITH (McLean County)
Murrell's Guest Home (6)
ASHLAND (Cass County)
Burch Home (10)
ASHMORE (Coles County)
Ashmore Estates (42)
BARTONVILLE (Peoria County)
Martin's Sheltered Home (28)
10 McClure Ct.
BARRY (Pike County)
Tittsworth Sheltered Care Home (8)
Rogers St.
BELLEVILLE (St. Clair County)
Gorski Old Folks Home (12)
1412 W. Main St.
Gribler Sheltered Care Home (15)
511 S. Charles St.
Heidelberg Retirement Home (16)
200 Abend St.
Weier Retirement Home (28)
5 Gundlach Pl.
BENTON (Franklin County)
Cockrum Sheltered Care Home (12)
314 S. Main St.
Good Samaritan Sheltered Care Home (13)
904 E. Main St.
Higgerson's Home (14)
209 N. Eighth St.
Mary Grace Sheltered Care Home (12)
112 Smith St.
Severin Sheltered Care Home (12)
105 Mill St.
Shady Rest Sheltered Care (18)
114 E. Webster St.
Wertz's Sheltered Care Home (13)
217 Pope St.
BETHANY (Moultrie County)
White Shelter Care Home (19)
513 E. Main St.
BLOOMINGTON (McLean County)
Eden's Sheltered Care Home (12)
1108 N. Prairie St.
Golden Age Home (19)
412 N. Roosevelt Ave.
Hanson Sheltered Care Home (17)
909 S. Center St.
Lowry Shelter Care Home (10)
903 W. Mullberry St.
Rusk Haven Shelter Home (42)
102 Greenwood Ave.
BLUE ISLAND (Cook County)
Stocker's Sheltered Care Home (12)
2346 Union St.
BRADFORD (Stark County)
Bradford Home (23)
214 E. Main St.
BRADLEY (Kankakee County)
Evans Shelter Care Home (7)
496 S. Wabash St.
BRIGHTON (Jersey County)
Post Sheltered Care Home (12)
Strack St., P.O. Box 161
BUNKER HILL (Macoupin County)
Hammond Shelter Care Home (26)
512 S. Franklin
BUSHNELL (McDonough County)
Daly's Golden Age Home (17)
257 E. Hail St.
CAMBRIDGE (Henry County)
Pine Lodge Home (17)
112 E. Center St.
CANTON (Fulton County)
Sunset Home (46)
135 S. First St.
Sunset Sheltered Care Home No. 2 (52)
129 S. First Ave.
CARTHAGE (Hancock County)
Welborn Shelter Care Home No. 2 (17)
140 Main St.
CASEY (Clark County)
Rude's Goodwill Shelter Home (12)
110 E. Monroe St.
CENTRALIA (Clinton County)
Brookside Manor, Inc. (41)
2000 W. Broadway
CENTRALIA (Marion County)
Brewer Shelter Care Home (14)
603 N. Walnut St.
Centralia Friendship House, Inc. (58)
1000 E. McCord St.
Centralia Shelter Care (20)
620 E. Broadway
CHAMPAIGN (Champaign County)
LaDow Sheltered Care Home (23)
406 S. Prairie St.
Pleasant Manor (15)
211 E. Clark St.
CHARLESTON (Coles County)
Teaters Sheltered Care Home (32)
Fifth and Jackson Sts.
Young Sheltered Care Home (18)
763 Tenth St.
CHEBANSE (Iroquois County)
Morgan Manor (10)
243 S. First St.
CHENOA (McLean County)
Rose Lawn Sheltered Care Home No. 2 (20)
324 Weir St.
CHESTER (Randolph County)
Padgett's Pot-A-Pourri Rest Home (34)
647 State St.
CHICAGO (Cook County)
Boulevard Home (19)
4533 W. Washington Blvd.
Continental Medical Management Corp. (32)
5148 S. Prairie Ave.
Jewish Peoples Convalescent Home (37)
6512 N. California Ave.
Kraus Home, Inc. (27)
1620 W. Chase Ave.
CLINTON (DeWitt County)
Burns Sheltered Care (5)
930 N. George

COBDEN (Union County)
Tripp Sheltered Care Home (28)
Box 323
COLLINSVILLE (Madison County)
Butler Home (16)
413 Vandalia St.
COULTERVILLE (Randolph County)
Coulterville Sheltered Care Home (21)
Seventh and Cedar Sts.
DALLAS CITY (Henderson County)
Welborn Sheltered Care Home (10)
69 E. Main St.
DANVERS (McLean County)
Holman Shelter Care Home (18)
300 E. Exchange St.
DECATUR (Macon County)
Farrar Sheltered Care Home (14)
1860 N. Broadway St.
Gladville Home (12)
1013 W. Wood St.
Lindsey Rest Home (7)
737 W. Wood St.
DONGOLA (Union County)
Keller Sheltered Care Home (27)
Box 634
DUQUOIN (Perry County)
Miller Sheltered Care Home (18)
24 S. Line St.
Open Arms Shelter (21)
200 N. Franklin
EAST ST. LOUIS (St. Clair County)
Carr Sheltered Care Home (9)
3112 Bond St.
Popejoy's Retirement Home (27)
1504 Illinois Ave.
EFFINGHAM (Effingham County)
Ireland Sheltered Care Home (7)
111 Forest St.
Marks Sheltered Care Home (22)
500 Clinton Ave.
ELDORADO (Saline County)
Murray Hotel (34)
900 Fifth St.
ELGIN (Kane County)
The Oliver Annex (11)
364 St. Charles St.
EL PASO (Woodford County)
Elderly Citizens Home (24)
Main St.
Tobien Elderly Citizens Home (27)
408 First St.
ENFIELD (White County)
Fields Shelter Care Home (20)
W. Main St.
FAIRFIELD (Wayne County)
Fair Haven Shelter Care Home (9)
507 W. Elm St.
FLORA (Clay County)
Anderson's Sheltered Care Home (12)
201 E. Third St.
Cattengaim Shelter Care (8)
215 W. North Ave.
Ferguson Sheltered Care Home (6)
520 W. North Ave.
Raber Sheltered Care Home (6)
409 E. Third St.
GALESBURG (Knox County)
Barre's Sheltered Care Home (13)
1179 E. Main St.
The Evergreens (14)
1188 W. Main St.
Lee's Sheltered Care Home (14)
736 N. Kellogg St.
GALVA (Henry County)
Galva Manor (27)
309 N. First St.
GOLCONDA (Pope County)
Millis Sheltered Care (10)
Monroe St.
Rose View Sheltered Care Home (10)
Washington and Harrison Sts.
GRAYVILLE (White County)
Hillcrest Home (13)
320 W. South St.
GREENFIELD (Greene County)
Hospitality House Sheltered Care (21)
212 Walnut St.
GREENUP (Cumberland County)
Peters Shelter Care Home (32)
308 N. Kentucky St.
GREENVILLE (Bond County)
Hilltop House (16)
202 N. Fourth St.
Horsfall Sheltered Care Home (52)
201 S. Second St.
HARDIN (Calhoun County)
Hardin Sheltered Care Home (14)
County Road St.
HERRIN (Williamson County)
Mattingly Sheltered Care Home (19)
700 N. 14th St.
Park Avenue Sheltered Care Home (33)
Rt. 148, P.O. Box 68
HEYWORTH (McLean County)
Lush Sheltered Care Home (15)
303 E. Main St.
IRVING (Montgomery County)
Mi-Edd Shelter Home (12)
JACKSONVILLE (Morgan County)
Bell Sheltered Care Home (21)
602 Jordan St.
Blue Sheltered Care Home (6)
506 W. Morton Ave.
Hardy Sheltered Care Home (14)
830 W. College Ave.
Hoots Rest Home (16)
717 E. Douglas St.
Parker Sheltered Care Home (20)
203 W. Beecher Ave.
Rosedale Sheltered Care Home (16)
220 Brown St.
Smith-Tucker Sheltered Care Home No. 1 (26)
606 N. Church St.
Smith-Tucker Sheltered Care Home No. 2 (14)
616 N. Church St.

JERSEYVILLE (Jersey County)
Alma's Shelter Care Home (26)
301 W. Pine St.
Stark's Sheltered Care Home (20)
600 N. Liberty St.
JOHNSTON CITY (Williamson County)
Cazaleen's Sheltered Care Home (13)
207 E. Fifth St.
Maple House Shelter Care (23)
207 E. Third St.
Maple House Sheltered Care Home No. 2 (23)
205 E. 3rd St.
Nellie Ernfelt Home (31)
R. R. 1
JONESBORO (Union County)
City Sheltered Care Home (14)
201 Broad St.
Gibbs Sheltered Care Home (6)
204 S. Pecan St.
Henard Sheltered Care Home (15)
204 S. Main St.
Spurlock Shelter Care Home (35)
Jonesboro Square
KAMPSVILLE (Calhoun County)
Smith Sheltered Care Home (12)
KANKAKEE (Kankakee County)
Bethel Shelter Home (11)
556 E. Oak St.
Geeding Shelter Home (16)
139 S. Greenwood Ave.
J. C. Good Shelter Home (16)
195 N. Entrance Ave.
Oaklawn Home (16)
191 N. Washington Ave.
KEWANEE (Henry County)
Kewanee Manor (22)
218 S. Tremont St.
LaHARPE (Hancock County)
Gillett Home (7)
W. Main St.
Gillett Home No. 2 (12)
W. Main St.
Hoosier Sheltered Care Home (15)
114 Archer Ave.
LeROY (McLean County)
LeRoy Home (24)
902 N. Mill St.
LEXINGTON (McLean County)
Rose Lawn Shelter Care Home (22)
207 N. Elm St.
Three Oaks Sheltered Care Home (20)
306 W. South St.
LOUISVILLE (Clay County)
Twilight Haven (18)
Hiriam St. & Rt. 45
LOVINGTON (Moultrie County)
Gaddis Sheltered Care Home, Inc. (26)
240 E. State St.
MARION (Williamson County)
Lee Manor (30)
1305 W. Main St.
Miner Sheltered Care Home (20)
205 E. Marion St.
MARSHALL (Clark County)
Dunkel Home (20)
325 S. Sixth St.
Marshall Christian Hotel (34)
805 Archer Ave.
MARTINSVILLE (Clark County)
Glendening Home (24)
25 S. Washington St.
McHENRY (McHenry County)
Shan Gra-La Sheltered Care Home (8)
3820 W. Idyldell Rd.
METROPOLIS (Massac County)
Angelly Sheltered Care (8)
202 Metropolis St.
Care Homes, Inc. (33)
205 Metropolis St.
Senior Citizens Retirement Home (27)
308 W. Third St.
MILFORD (Iroquois County)
Golden Jubilee Homes (13)
28 S. West Ave.
MINONK (Woodford County)
Minonk Manor, Inc. (22)
221 Locust St.
MOLINE (Rock Island County)
Hendren's Sheltered Care Home (12)
2602 Sixth Ave.
Hensley Home (13)
1111 Fifteenth St.
Paul's Boarding Home (14)
849 Fifteenth St.
MORTON (Tazewell County)
Morton Home (20)
424 N. Main St.
MT. CARMEL (Wabash County)
Chestnut Sheltered Care Home (24)
218 Chestnut
Ladies Lodge (21)
318 W. Second St.
Shurtleff Annex (24)
416 Plum St.
Shurtleff Shelter Care Cottage (8)
429 E. Fifth St.
Williamson Shelter Care Home (17)
407 W. Fourth St.
MT. OLIVE (Macoupin County)
Albert Sheltered Care Home (13)
101 W. Fourth St.
MT. STERLING (Brown County)
Mt. Sterling Sheltered Care (15)
117 E. South St.
MT. VERNON (Jefferson County)
Hearthside Sheltered Care Home (21)
318 N. Ninth St.
MULBERRY GROVE (Bond County)
Smith's Sheltered Care Home (17)
111 S. Maple St.
MURPHYSBORO (Jackson County)
River Bend Manor (65)
1501 Shomaker Dr.
NEWTON (Jasper County)
duMont Sheltered Care Home (22)
438 S. Lafayette St.

OBLONG (Crawford County)
Fouty's Sheltered Care Home (16)
507 S. Garfield St.
Hart Sheltered Care (14)
403 N. Range St.
ODELL (Livingston County)
The Odell Shelter, Inc. (25)
17 Henry St.
O'FALLON (St. Clair County)
Andricks Shelter Care (8)
135 Main St.
OLD MARISSA (St. Clair County)
Old Marissa Sheltered Care Home (17)
OLNEY (Richland County)
Braden Sheltered Care (9)
230 E. North Ave.
Colonial Manor Sheltered Care (31)
327 S. Morgan St.
Marks Sunset Manor (21)
1044 Whittle
Miller Sheltered Care House (11)
103 E. Lafayette St.
Rachel Moore Shelter Care (6)
413 S. Morgan
ONARGA (Iroquois County)
Jones Sheltered Care (11)
317 N. Walnut
OQUAWKA (Henderson County)
Oquawka Shelter Home (17)
PALMYRA (Macoupin County)
Light House Shelter (10)
PARIS (Edgar County)
Colonial Home (6)
623 N. Central Ave.
Hefner Shelter Care (6)
210 Chestnut St.
Matthews Shelter Care Home (15)
414 Douglas St.
Sanders Sheltered Care Home (11)
813 Tenbrook
PAW PAW (Lee County)
Pfeiffer Sheltered Care Home (10)
PEKIN (Tazewell County)
B. J. Perino Shelter Care Home, Inc. (54)
601-603 Prince St.
PEORIA (Peoria County)
Senior Citizens Sheltered Care Home (11)
302 W. Third St.
Waldo Home (45)
405 N. Perry
PERU (LaSalle County)
Hillview Manor (12)
2106 Market St.
PITTSFIELD (Pike County)
Pittsfield Sheltered Care House (10)
411 W. Washington St.
PLANO (Kendall County)
Wesley Haven, Inc. (20)
218 N. Center
PLYMOUTH (Hancock County)
Thomas Sheltered Care Home (14)
Box 323
PONTIAC (Livingston County)
Northcrest Manor (13)
732 N. Mill St.
PRINCEVILLE (Peoria County)
Seven Oaks (13)
Douglas and Tremont Sts.
QUINCY (Adams County)
Bacon Sheltered Care Home (9)
1435 N. Fifth St.
Beever Sheltered Care Home (22)
327 Elm St.
Frances Shelter Care Home (17)
431 Locust St.
Sims Shelter House (7)
1619 N. Fourth St.
ROCHELLE (Ogle County)
Joyce Old Folks Home (16)
609 N. Sixth St.
ROCK FALLS (Whiteside County)
Riverview Haven (16)
308 E. 2nd St.
ROCKFORD (Winnebago County)
Bethany House (14)
412 N. Court St.
Parkview Sheltered Care Home (29)
408 N. Horsman St.
ROODHOUSE (Greene County)
Dameron Shelter Care Home (12)
114 E. Palm St.
RUSHVILLE (Schuyler County)
Lacey's Care Home (18)
239 W. Clay St.
ST. JACOB (Madison County)
Nolan Sheltered Care Home (25)
R. R. 1
SALEM (Marion County)
Hogge's Sheltered Care Home (19)
521 E. Church St.
SANDOVAL (Marion County)
Finn's Sheltered Care Home (18)
W. North Second St.
SAYBROOK (McLean County)
Maplebrook (15)
Main St.
SESSER (Franklin County)
Nixt Sheltered Care Home (4)
303 W. Mathew
SHELDON (Iroquois County)
Sheldon Sheltered Home (44)
170 W. Concord
SIMPSON (Pope County)
Shawnee Shelter Care (14)
R. R. 2
SPARTA (Randolph County)
Kirsby Shelter Home (22)
411 S. St. Louis St.
SPRINGFIELD (Sangamon County)
Gannar Cerebral Palsy Home (11)
910 S. Second St.
Lane Bryant Retirement Home (14)
1712 E. Washington St.

Peart Sheltered Care Home (21)
1010 S. Second St.
Sunshine Guest Home (16)
607 S. Fifth St.
Tomlin Retirement Home (11)
609 N. Fourth St.

STOCKTON (Jo Daviess County)
Brog's Sheltered Care Haven (13)
205 E. Benton St.

STREATOR (LaSalle County)
Hillview Sheltered Care Home (18)
518 S. Bloomington St.

SULLIVAN (Moultrie County)
Beals Sheltered Care Home (28)
13 S. McClellan St.

SYCAMORE (DeKalb County)
The Driscoll Home (15)
309 N. California

TALLULA (Menard County)
Garden View (13)
N. Ewing

TILTON (Vermilion County)
Smoot Memorial Home (8)
215 W. Sixth St.
Mrs. Etta R. Wangler Anderson
Sheltered Care Home (7)
605 E. Fifth St.

URBANA (Champaign County)
Clark Sheltered Care Home (13)
811 W. Oregon St.
Lustig Sheltered Care Home (16)
904 W. Clark St.

VANDALIA (Fayette County)
The Heritage House (44)
Rt. 185 West

VIRGINIA (Cass County)
Virginia Sheltered Care Home (18)
132 E. Illini St.

WARSAW (Hancock County)
Carlson Sheltered Care Home (22)
150 Main St.

WASHINGTON PARK (St. Clair County)
Park Retirement Home (33)
2246 N. 57th, East St. Louis

WATSEKA (Iroquois County)
Pleasant Lodge (28)
590 E. Grant St.

WAUKEGAN (Lake County)
Marseilles Retirement Home, Inc. (28)
604 N. Genesee St.

WAVERLY (Morgan County)
Witt Sheltered Care Home (18)
405 S. Miller St.

WEST FRANKFORT (Franklin County)
Peacock Sheltered Care Home (19)
309 W. Oak St.
Rankin Sheltered Care Home (6)
312 E. Fourth St.
Smith Sheltered Care Home (15)
512 S. Cherry St.
Wood Sheltered Care Home (7)
609 S. Monroe

WEST SALEM (Edwards County)
Golden Acres, Inc. (33)

WHEATON (DuPage County)
Tall Tree Guest Home (16)
R. R. 1, Box 34

WHITE HALL (Greene County)
Elliott Sheltered Care Home (14)
601 N. Main St.
Ford Sheltered Care Home (14)
535 N. Main St.
Powell Sheltered Care Home (7)
144 E. Lincoln St.
Shanahan Sheltered Care Home (10)
431 Centennial St.

WINCHESTER (Scott County)
Oak Rest Sheltered Care Home (18)
206 High St.

YORKVILLE (Kendall County)
Himes Sheltered Care Home (11)
N. Bridge St.

ZION (Lake County)
Robbins Home (9)
3220 Emmans Ave.

HOMES FOR THE AGED

In this section, the following symbols are used: A—sheltered care facilities, B—nursing care facilities, and C—special geriatric facilities.

ALHAMBRA (Madison County)
Hitz Memorial Home—(AB-25)
Belle St.

ALTON (Madison County)
The Loretto Home—(A-60)
417 Prospect St.

ARLINGTON HEIGHTS (Cook County)
Lutheran Home and Service for the Aged—
(AB-203)
800 W. Oakton St.

AURORA (Kane County)
Jennings Terrace—(AB-106)
275 S. LaSalle St.
Sunnymere, Inc.—(AB-48)
925 Sixth Ave.

BELLEVILLE (St. Clair County)
Meredith Memorial Home—(A-85)
Public Square
St. Paul's Home—(AB-98)
1021 W. "E" St.

BENSENVILLE (DuPage County)
Bensenville Home Society—(AB-120)
York and Memorial Dr.
BROOKFIELD (Cook County)
The British Home—(AB-90)
31st and McCormick Ave.
CANTON (Fulton County)
Nancy and Ann Kelley Home for the Aged—(A-10)
344 W. Chestnut St.
CARLYLE (Clinton County)
St. Mary's Home for the Aged—(A-42)
501 Clinton St.
CHAMPAIGN (Champaign County)
The Garwood Home—(A-29)
1515 N. Market St.
CHESTER (Randolph County)
St. Ann's Home—(AB-45)
770 State St.
CHICAGO (Cook County)
Augustana Home for the Aged—(AB-140)
7540 Stony Island Ave.
Bethany Home—(AB-415)
5015 N. Paulina St.
Bohemian Home for the Aged—(AB-150)
5061 N. Pulaski Rd.
Chicago Holland Home for the Aged—(A-140)
240 W. 107th Pl.
Church Home for Aged Persons—(AB-90)
5435-45 Ingleside Ave.
Cosmopolitan Community Home—(A-25)
51 E. 53rd St.
Covenant Home—(AB-101)
2725 W. Foster Ave.
Drexel Home, Inc.—(ABC-230)
6140 Drexel Ave.
Fridhem Baptist Home—(AB-95)
11404 S. Bell Ave.
George J. Goldman Memorial Home for the Jewish Aged—(AB-37)
1152 W. Farwell Ave.
Home for the Association of Jewish Blind (A-43)
3525 W. Foster Ave.
Jane Dent Home—(A-22)
4430-32 Vincennes Ave.
Jewish Home for the Aged—(ABC-286)
1648 S. Albany Ave.
Methodist Old Peoples Home—(AB-191)
1415 Foster Ave.
Northwest Home for the Aged—(AB-52)
2201 N. Sacramento Ave.
Norwegian Lutheran Bethesda Home (AB-150)
2833 N. Nordica Ave.
Norwood Park Home—(AB-140)
6016 N. Nina Ave.
The Old People's Home of the City of Chicago—(AB-125)
909 Foster Ave.
Park View Home—(ABC-142)
1401 N. California Ave.
Sacred Heart Home—(AB-200)
1550 S. Albany Ave.
St. Augustine—(AB-162)
2358 N. Sheffield Ave.
St. Joseph's Home for the Aged—(AB-178)
2650 N. Ridgeway Ave.
St. Paul's House—(A-70)
3831 N. Mozart St.
Selfhelp Home for the Aged—(AB-42)
4941 S. Drexel Blvd.
Society for the Danish Old People's Home (AB-89)
5656 N. Newcastle Ave.
Washington and Jane Smith Home—(ABC-190)
2340 W. 113th Pl.
DANVILLE (Vermilion County)
Webster Memorial Home—(A-11)
903 N. Logan Ave.
ELBURN (Kane County)
Fellowship Deaconry—(A-11)
526 N. Main St.
ELGIN (Kane County)
Oak Crest Residence—(AB-43)
204 S. State St.
EUREKA (Woodford County)
Apostolic Christian Home at Eureka (AB-48)
610 W. Cruger St.
Maple Lawn Homes—(AB-96)
Box 37, R.R. 2
EVANSTON (Cook County)
Alonzo Mather Aged Ladies Home (AB-203)
1615 Hinman Ave.
The Georgian, Division of Methodist Old Peoples Home—(AB-245)
422 Davis St.
Homecrest Foundation—(A-50)
1430 Chicago Ave.
James C. King Home for Old Men (AB-84)
1555 Oak Ave.
Lake Crest Villa—(A-32)
2601 Central St.
Pioneer Place—(AB-113)
2320 Pioneer Rd.
Presbyterian Home—(AB-303)
3200 Grant St.
FAIRBURY (Livingston County)
Fairview Haven, Inc.—(AB-43)
605-609 N. Fourth
FOREST PARK (Cook County)
Altenheim (German Old Peoples Home) (AB-250)
7824 Madison St.
FREEPORT (Stephenson County)
Freeport-Bensenville Home—(A-20)
822 W. Stephenson St.
Park View Home—(A-25)
South Park Blvd.
St. Joseph Home for the Aged—(AB-116)
649 E. Jefferson St.

GIRARD (Macoupin County)
The Home—(A-48)
GLENVIEW (Cook County)
Maryhaven Village for Aged and Blind (AB-166)
1700 E. Lake Ave.
GOLDEN (Adams County)
Golden Good Shepherd Home, Inc.—(AB-48)
GURNEE (Lake County)
Independent Order of Vikings Home for Aged Members—(AB-35)
Grand Ave.
HIGHLAND (Madison County)
Highland Home—(A-27)
1600 Walnut St.
HIGHLAND PARK (Lake County)
Villa St. Cyril—(AB-82)
1111 St. Johns Ave.
HINSDALE (Cook County)
King-Bruwaert House—(AB-79)
6101 County Line Rd.
HINSDALE (DuPage County)
Godair Home—(AB-53)
6259 S. Madison St.
JACKSONVILLE (Morgan County)
Illinois Christian Home, Inc.—(AB-110)
873 Grove St.
JOLIET (Will County)
Our Lady of Angels Retirement Home (AB-100)
1201 Wyoming Ave.
St. Patrick Retirement Hotel—(AB-203)
22 E. Clinton St.
Salem Home for the Aged—(AB-82)
1313 Rowell Ave.
JUSTICE (Cook County)
Rosary Hill Convalescent Home—(AB-75)
9000 W. 81st St.
KEWANEE (Henry County)
St. Bernadette Manor—(A-24)
Elliott St.
The Whiting Home—(A-10)
320 S. Chestnut St.
KNOXVILLE (Knox County)
Illinois P.E.O. Home—(A-35)
415 E. Main St.
LaGRANGE PARK (Cook County)
Plymouth Place—(AB-182)
315 N. LaGrange Rd.
LAKE VILLA (Lake County)
American Aid and Old Peoples Home Society—(A-18)
Grand Ave.
LAWRENCEVILLE (Lawrence County)
The Methodist Home—(AB-143)
1601 S. Sixteenth St.
LEMONT (Cook County)
Holy Family Villa—(AB-112)
123rd St.
Mother Theresa Home—(AB-54)
1270 Main St.
LINCOLN (Logan County)
Deaconess Memorial Home Annex—(A-20)
315 Eighth St.
MACOMB (McDonough County)
Everly House—(A-38)
811 S. Lafayette St.
MACON (Macon County)
Eastern Star Home at Macon—(AB-111)
MATTOON (Coles County)
Illinois I.O.O.F. Old Folk's Home—(AB-225)
E. Lafayette St.
MAYWOOD (Cook County)
Maywood Baptist Home—(AB-229)
316 Randolph St.
Maywood Home for Soldiers Widows—(A-32)
224 N. First Ave.
MEADOWS (McLean County)
Meadows Mennonite Home—(AB-58)
MENDOTA (LaSalle County)
Mendota Lutheran Home—(AB-42)
504 Sixth St.
MORRISON (Whiteside County)
Resthaven Home of Whiteside County—(A-23)
Maple Ave.
MORTON GROVE (Cook County)
Bethany Terrace Retirement and Nursing Home—(AB-137)
8425 N. Waukegan Rd.
MT. CARROLL (Carroll County)
Caroline Mark Home—(A-16)
222 E. Lincoln St.
MT. MORRIS (Ogle County)
Pinecrest Manor—(AB-122)
414 S. McKendrie Ave.
NEW ATHENS (St. Clair County)
New Athens Home—(AB-36)
203 S. Johnson St.
NILES (Cook County)
St. Andrew Home for the Aged—(AB-225)
7000 N. Newark Ave.
St. Benedict's Home for the Aged—(AB-52)
6930 W. Touhy Ave.
NORMAL (McLean County)
Shamel Manor—(A-100)
509 N. Adelaide
NORRIDGE (Cook County)
Central Baptist Home for the Aged—(AB-94)
7901 W. Lawrence Ave.
NORTHLAKE (Cook County)
Villa Scalabrini—(AB-88)
Wolf Rd. and Palmer St.
NORTH RIVERSIDE (Cook County)
Scottish Old Peoples Home—(AB-50)
28th St. and DesPlaines Rd.
OTTAWA (LaSalle County)
Cora J. Pope Home—(A-14)
116 W. Prospect St.
Pleasant View Luther Home—(AB-146)
505 College Ave.
PALATINE (Cook County)
St. Joseph's Home for the Elderly—(AB-250)
80 W. Baldwin Rd.

PARK RIDGE (Cook County)
St. Matthew Lutheran Home—(AB-90)
1601 N. Western Ave.
PAXTON (Ford County)
Illinois Knight Templar Home for the Aged Infirm—(B-29)
706 S. Washington St.
PEORIA (Peoria County)
Apostolic Christian Home—(A-32)
7023 Skyline Dr.
Christian Buehler Memorial Home—(AB-223)
3415 N. Sheridan Rd.
Guyer Memorial Home—(A-18)
201 W. Columbia Terr.
John C. Proctor Endowment Home—(AB-224)
1301 N.E. Glendale Ave.
St. Joseph's Home for the Aged—(AB-200)
2223 W. Heading Ave.
PEOTONE (Will County)
Peotone Bensenville Home—(AB-29)
Wood and West Sts.
PONTIAC (Livingston County)
Evenglow Lodge—(A-151)
201 E. Washington St.
Humiston Haven—(AB-74)
300 W. Lowell St.
PRICETON (Bureau County)
Adeline E. Prouty Home—(A-8)
508 Park Ave. East
QUINCY (Adams County)
Anna Brown Home for the Aged—(AB-35)
1507 N. Fifth St.
Good Samaritan Home—(AB-110)
2130 Harrison St.
Methodist Sunset Home—(AB-144)
418 Washington St.
St. Vincent's Home—(A-130)
1340 N. Tenth St.
ROCKFORD (Winnebago County)
Eastern Star Home of Rockford—(AB-102)
2400 S. Main St.
P. A. Peterson Home—(AB-25)
1301 Parkview Ave.
Wesley Willows, a Methodist Retirement Home—(AB-228)
4141 N. Rockton Ave.
Winnebago Home for the Aged—(AB-39)
Box 2, Safford Rd.
ROCK ISLAND (Rock Island County)
Cleveland Home for the King's Daughters of Illinois, Inc.—(A-23)
805 Nineteenth St.
Huber Memorial Home—(A-23)
1000—30th St.
SPRINGFIELD (Sangamon County)
Carrie Post King's Daughters Home for Women—(A-38)
541 Black Ave.
Illinois Presbyterian Home—(A-61)
W. Lawrence at Chatham Rd.
Mary Bryant Home for the Blind—(A-48)
1100 S. Fifth St.
St. Joseph's Home for the Aged—(A-125)
S. Sixth Street Rd.
SULLIVAN (Moultrie County)
Illinois Masonic Home—(AB-310)
Rt. 121 East
Titus Memorial Presbyterian Home—(A-11)
513 N. Worth St.
TECHNY (Cook County)
St. Ann's Home and Infirmary—(AB-200)
Waukegan Rd.
VIRDEN (Macoupin County)
Mothers' Memorial Baptist Home—(AB-27)
402 W. Loud St.
WHEELING (Cook County)
Addolorata Villa—(AB-85)
Hwy. 83, McHenry Rd.
WILMETTE (Cook County)
Baha'i Home—(A-20)
401 Greenleaf Ave.
Maryhaven, Inc.—(AB-113)
2228 Beechwood Ave.
WOODSTOCK (McHenry County)
Sunset Manor, Inc.—(AB-54)
920 Seminary Ave.

EXTENDED CARE FACILITIES

The facilities listed below have been surveyed by the Illinois Department of Public Health and certified by the U.S. Department of Health, Education, and Welfare as Extended Care Facilities for Medicare beneficiaries, as of Aug. 1, 1968. The number of certified beds within the facility is indicated.

ABINGDON
Abingdon Nursing Home (74)

ALTON
Eunice E. Smith Home (64)

ANNA
Union County Hospital (19)

ARTHUR
The Arthur Home (41)

AUBURN
Parks Memorial Home (22)

AURORA
Borealis Nursing Home (112)
St. Charles Hospital (26)

AVON
Avon Nursing Home (48)

BELLEVILLE
Memorial Nursing Home (111)
St. Elizabeth's Home (54)

BENTON
Franklin Hospital Skilled Nursing (81)

BERWYN
Fairfax Ger. & Conv. Center (31)
R N Convalescent Home (20)

BLOOMINGTON
Heritage Manor (47)

CARBONDALE
Styrest Nursing Home (54)
CARLINVILLE
Lake View Nursing Home (74)
CASEY
Casey Nursing Home (92)
CENTRALIA
Centralia Fireside House, Inc. (46)
CHARLESTON
Hilltop Nursing Home (25)
CHESTER
St. Ann's Home (45)
CHICAGO
All American Nursing Home (144)
Augustana Home for Aged (28)
Austin Congress Nursing Home (68)
Balmoral Home, Inc. (67)
Bethany Methodist Hosp. (87)
Brittany Terrace (49)
Bryn Mawr House, Inc. (183)
Drexel Home (132)
Elston Home (41)
Fargo Beach Home (149)
Fountainebleau Manor (32)
Fox River Rehab. Center (74)
Garden View Home (57)
Jewish Home for Aged (232)
Johnson Rehab. Nursing Home (76)
Kostner Manor (119)
Melbourne Convalescent Home (41)
Montgomery Convalescent Home(80)
Northwest Home for Aged (26)
Park View Home (31)
Rosewood Terrace (70)
South Shore Kosher Rest Home (111)
South Shore Pavilion (113)
Sovereign Home (29)
Vincennes Manor (110)
Wellington Plaza (91)
Westwood Manor (115)
Wrightwood Nursing Home (90)
CHICAGO HEIGHTS
Riviera Manor (55)
Suburban Convalescent Home (49)
CHILLICOTHE
ParkHill Nursing Home (66)
COAL VALLEY
Oak Glen Nursing Home (286)
COLCHESTER
Colchester Nursing Home (49)
DANVILLE
Colonial Manor (24)
DECATUR
Americana Nursing Center of Decatur (65)
Lakeshore Manor (28)
DEKALB
DeKalb Public Hospital (15)
Pine Acres Retirement Center (60)
DESPLAINES
Brookwood Convalescent Center, Inc. (111)
Golf Road Pavilion (142)
DIXON
Orchard Glen (54)
DUQUOIN
Fair Acres Nursing Home (29)
ELMHURST
Elmhurst Nursing Home (42)
ELGIN
Simpson House (67)
EVANSTON
Dobson Plaza Nursing Home, Inc. (52)
Presbyterian Home (75)
Three Oaks Nursing Center (124)
EVERGREEN
Evergreen Gardens, Inc. (40)
Peace Memorial Home (60)
FLORA
Flora Nursing Center (24)
FULTON
Harbor Crest Nursing Home (49)
GALESBURG
Americana Nursing Center (34)
GODFREY
Blu-Fountain Manor Nursing Home (29)
GENESEO
Hammond Henry Dist. Hospital (48)
GLENVIEW
Golf Mill Nursing Home (166)
HARVEY
Heather Manor Convalescent Center (49)
HIGHLAND PARK
Villa St. Cyril (39)
HIGHWOOD
Pavilion of Highland Park (46)
HILLSIDE
Oakridge Convalescent Home (24)
HOPEDALE
Hopedale Nursing Home (86)
JACKSONVILLE
Modern Care Conv. & Nsg. Home (40)
JOLIET
Americana Nursing Center of Joliet (47)
Our Lady of Angels Ret. Home (22)
Salem Home for Aged (26)
St. Patricks Residence (20)
KANKAKEE
Americana Nursing Center of Kankakee (92)
Riverside Hospital (50)
KEWANEE
Spoon River Residence (41)
LACON
St. Joseph Nursing Home (54)
LAGRANGE
LaGrange Colonial Manor (49)
LAWRENCEVILLE
Methodist Home for the Aged (40)
LEWISTOWN
Clarytona Manor (25)
LIBERTYVILLE
Lake County Nursing Home (83)
LINCOLN
Abraham Lincoln Mem. ECF (58)
Christian Nursing Home (25)
Mary Henry Nursing Home (52)

LITCHFIELD
Litchfield Nursing Home (16)
LOVES PARK
Fountain Terrace (49)
MACOMB
Americana Nursing Center of Macomb (31)
MARSHALL
Burnside Nursing Home (90)
MATTOON
Douglas Nursing Center (49)
MENDOTA
Sunrise Nursing Home (49)
MOLINE
Americana Nursing Center (67)
MORTON
Restmor, Inc. (58)
MT. MORRIS
Pinecrest Manor (50)
MT. VERNON
Good Samaritan Hosp. ECF (20)
Hickory Grove Manor (54)
MT. ZION
Woodland Inc. Nursing Home (70)
MUNDELEIN
North Riverwood Center, Inc. (65)
NAPERVILLE
Americana Nursing Center (97)
NEWTON
Newton Rest Haven (29)
NILES
Pleasantview Conv. Nursing Ctr. (91)
NORMAL
Americana Nursing Center (51)
Brokaw Hospital (50)
NORTHBROOK
Edenview Convalescent Home (142)
Northbrook Nursing Home (71)
OAK FOREST
Oak Forest Hospital (1,429)
OAK LAWN
Monticello Convalescent Ctr. (50)
Oak Lawn Convalescent Home (38)
Parkside Gardens Nursing Home (77)
O'FALLON
Parkview Colonial Manor (107)
OLNEY
Burgin Manor Nursing Home (26)
OTTAWA
Highland San. & Conv. Home (63)
Pleasant View Luther Home (54)
PALATINE
Plum Grove Nursing Home (46)
PARK RIDGE
St. Matthew Lutheran Home (29)
PEKIN
Pekin Mem. Hosp. (34)
PEORIA
Americana Nursing Center (65)
High View Nursing Home (40)
PEORIA HEIGHTS
Fireside House, Inc. (54)
PERU
Heritage Manor (55)
PETERSBURG
Menard Convalescent Center (18)
PITTSFIELD
Pittsfield Nurs. Home (74)
PONTIAC
Evenglow Lodge (40)
Humiston Haven (20)
QUINCY
Illinois Soldiers & Sailors Home (10)
Methodist Sunset Home (17)
St. Joseph Hall (72)
ROCHELLE
Americana Nursing Center (49)
ROCK FALLS
Colonial Acres Rest Home (55)
ROCKFORD
Alma Nelson Manor (36)
Americana Nursing Center Rockford (72)
Riverside Manor (59)
Wesley Willows (30)
ROSICLARE
Hardin County General Hosp. (4)
SALEM
Twin Willows Nursing Center (28)
SHELBYVILLE
Shelby County Mem. Hospital (20)
Young's Shelbyville Restorium (22)
SKOKIE
Old Orchard Manor (61)
Village Nursing Home (84)
S. CHICAGO HEIGHTS
Suburgan Con. Nursing Home (49)
SPRINGFIELD
Americana Nursing Center (72)
Everett McKinley Dirksen Home (109)
Rutledge Manor Care Home, Inc. (31)
STERLING
Colonial Acres Rest Home (70)
STREATOR
Heritage Manor (27)
SULLIVAN
East View Manor (52)
SUMNER
Red Hills Rest Haven Nursing Home (44)
SWANSEA
Castle Haven Nursing Home (51)
TAYLORVILLE
Meadow Manor (36)
TECHNY
St. Ann's Home & Infirmary (47)
TUSCOLA
Douglas County Jarman Memorial Hospital (6)
URBANA
American Nursing Center (50)
Fontana Nursing Care Center (47)
WATSEKA
Iroquois Resident Home (58)
WASHINGTON
Washington Nursing Center (88)

WATERLOO
Monroe County Nursing Home (60)

WAUKEGAN
Terrace Nursing Home (43)
Waukegan Pavilion Nursing Home (96)

WINFIELD
Abbey-Winfield Convalescent Home (49)

WHEATON
DuPage County Convalescent Home (53)

INDEPENDENT LABORATORIES

The Independent Laboratories listed below have been surveyed by the Illinois Department of Public Health and certified by the U.S. Department of Health, Education and Welfare as providers of service for Medicare beneficiaries as of August 2, 1968. The specific tests reimbursable by Medicare are indicated in parenthesis following the name of each laboratory:

A. Microbiology
B. Serology
C. Clinical Chemistry
D. Hematology
E. Immunohematology
F. Tissue Pathology
G. Exfoliative Cytology
H. All Clinical

ARGO
Argo Clinical Lab. (BCD)
6252 Archer Road 60501

ARLINGTON HEIGHTS
Arlington Medical Lab. (F)
1430 N. Arlington Heights Rd., 60004
Village Medical Lab., (CDE)
1009 S. Evergreen, 60005

AURORA
Clinical Lab. (H)
143 S. Lincoln, 60505

BARRINGTON
Barrington Medical Lab. (ABCD)
606 S. Northwest Hwy., 60010

BELLEVILLE
St. Clair Medical Lab. (ABCDFG)
301 W. Lincoln, 62220

BERWYN
Kenilworth Lab. (ABCDE)
6905 W. Cermak Rd., 60402
Medica Clinical Lab., (ABD)
3340 S. Oak Park Ave., 60403

BLOOMINGTON
Bloomington Cornbelt Biochmcl. Lab. (ABCD)
705 North East, 61701
Hans H. Stroink, M.D. (H)
214 Unity Bldg., 61701

BROADVIEW
Broadview Physicians Lab. (ABCDE)
220 W. Roosevelt, 60155

CHAMPAIGN
Doctors Bldg. Lab., (BCD)
301 E. Springfield, 61820

CHICAGO
Avenue Medical Lab. (ABCD)
5959 N. Washtenaw, 60645
A & D Medical Lab. (ABCDE)
3848 W. 63rd St., 60629
A. S. Cahan, M.D. (BCDE)
4010 W. Madison St., 60624
Accurate Medical Lab (ABCDE)
5959 N. Washtenaw, 60645
Almar Clinical Lab. (ABCDE)
2457 W. Peterson Ave., 60645
Anderson Clinical Lab. (BCDE)
811 W. Wellington, 60657
Apogee Medical Labs Inc. (ACD)
5962 Lincoln Ave., 60645
Aquinas Medical Lab. (C)
11102 S. Artesian Ave., 60655
Arcade Clinical Lab. (ACDE)
6355 Broadway, 60626
Associated Medical Lab., Inc. (ABCDE)
4753 Broadway, 60640
Auburn Clinical Lab. (BCD)
946 W. 79th St. 60620
Austin Clinical Lab. (BCDE)
5679 W. Madison St., 60644
Avenue Medical Lab. (ABCD)
11318 S. Michigan Ave., 60628
Bel-Aire Medical Bldg. Lab. (ACDEG)
8501 Cottage Grove 60619
Beverly-Sheridan Labs., Inc., (ABCD)
9449½ S. Ashland, 60620
Brooks Clinical Lab. (ABCDE)
4006 Milwaukee Ave., 60641
Central Doctors' Medical Lab (CD)
2715 N. Central 60639
Central X-Ray & Clinical Lab. (H)
111 N. Wabash, 60602
Chathan-Avalon Clinical Lab. (BCDE)
8222 Martin Luther King Dr.
Chemical Consulting Corp. (C)
6018 W. Fullerton 60639
Clearing Clinic, Inc. (ABCDE)
5548 W. 65th St., 60638
Colonial Medical Lab. (ABCD)
2024 W. 79th St., 60620
Doctors Medical Lab., Inc. (ABD)
11450 S. Michigan Ave., 60628
Drexal Home (CD)
6140 S. Drexel 60637
Drs. Mason & Baron (H)
2056 N. Clark St. 60614

Foster-Western Clinical Lab. (ABCDE)
5214 N. Western Ave., 60625
Gerber X-Ray & Clinical Lab. (ABCDE)
2400 W. Devon, 60645
Gerson Clinical Lab. (ACD)
1 N. Pulaski Rd., 60624
Highland Medical Labs. (ABCDE)
7922 S. Ashland Ave., 60620
Humboldt Clinical Lab. (D)
2018 S. Ashland, 60608
Hyde Park Medical Lab. (BCDG)
5240 S. Harper, 60615
K & K Clinical Lab., Inc. (ABCD)
5935 W. Addison, 60634
Kendon Medical Lab., Inc. (ABCD)
8625 S. Cicero, 60652
Letho Clinical Labs. (H)
1325 S. Racine, 60608
Marquette Medical Lab. (ABCDE)
6132 S. Kedzie, 60629
Mart X-Ray Lab., Co. (ACD)
7-110 Merchandise Mart, 60654
Maryhaven Medical Lab., Inc. (CD)
8700 S. Dante, 60619
Medic Clinical Lab. (B)
6317 S. Western Ave. 60636
Medical Associates of Chicago (H)
3233 Martin Luther King Dr.
Medical Center Clinical Labs. (CD)
3528 N. Ashland, 60657
Metro Lab. (H)
1737 W. Howard, 60626
Metro Lab. (H)
30 N. Michigan Ave., 60602
Metro Lab. (H)
2376 E. 71st St. 60649
Michael Reese Research Foundation (BDE)
530 E. 31st St., 60616
Midwest Cytology Lab. (G)
5707 N. Ashland Ave., 60626
Molay Medical Labs. (ABCD)
185 N. Wabash, 60601
Murphy—Uptown Clinical Lab (CD)
4763 Broadway 60640
North Beverly Clinical Lab. (BCDE)
1700 W. 87th St., 60620
North-Kimball Medical Labs. (BCDE)
1579 N. Milwaukee, 60622
Ogden Hill Medical Lab. (B)
3451 W. 63rd St. 60629
Omens Medical Bldg. Lab. (B)
5720 W. North Ave. 60639
P. M. D. Clinical Lab. (CD)
2017 W. 95th St. 60643
Parkview Home (ABCD)
1401 N. California, 60622
Parkway Labs. (ABCDE)
408 E. Marquette Rd., 60637
Pathology Associates (H)
55 E. Washington, 60602
Peterson-Western X-Ray Lab. (ABCDE)
2424 W. Peterson Ave., 60645
Physicians & Surgeons Clinical Lab (ABCDE)
6710 W. North Ave., 60635
S & S Medical Lab. (CD)
532 E. 47th St., 60653
Sarian Medical Labs. (ABCDE)
6257 S. Archer, 60638
Sauganash Medical & X-Ray Lab. (ABCD)
4833 W. Peterson, 60646
South East Medical Lab. (CD)
1832 E. 87th St., 60617
South Central Medical Lab. (ABCDE)
5050 S. State St., 60609
Thornburg Clinical Lab. (ABCDE)
720 N. Michigan 60611
Thornburg Clinical Lab (CD)
841 E. 63rd St. 60637
200 Clinical Lab. (BCDE)
200 E. 75th St., 60619
2011 Clinical Lab. (ABCD)
2011 E. 75th St., 60649
United Medical Lab., Inc. (H)
8 S. Michigan 60603
University Lab. (ABCDE)
5 S. Wabash, 60603
West Lawn Medical Lab. (ABCD)
4255 W. 63rd St., 60629
Westerly Medical Lab. (ABCDE)
10404 S. Western, 60643
Westridge Clinical Lab. (ABCD)
6450 N. California, 60645
Westside Clinical Lab. (CD)
3808 W. Roosevelt Rd., 60624
Zeitlin X-Ray & Clinical Lab. (BCDE)
2800 N. Milwaukee, 60619
63rd Medical Lab. (ABCDE)
749 W. 63rd St. 60621
95th St. X-Ray & Clinical Lab. (ABCDE)
243 W. 95th St. 60628

CICERO
Suburban Labs., Inc. (ABCD)
2137 S. Lombard, 60650

DECATUR
Central Clinical Lab. (ABCDE)
1314 N. Main, 62526

DEERFIELD
Colrad Clinical Labs. (ABCD)
747 Deerfield Rd., 60015

DEKALB
De Graffenried & Fisher Clinical Lab. (H)
1838 Sycamore Rd., 60115

DES PLAINES
De Ridge Clinical Lab. (ABCDE)
3200 Dempster, 60016

DIXON
Physicians Medical Lab. (ABCD)
101 First St., 61021

EAST ST. LOUIS
Appleton Lab. (BCD)
234 Collinsville Ave. 62201
Clinical Lab. (ABCDE)
4601 State St., 62201

ELGIN
Fox Valley Medical Lab. (H)
860 E. Summit, 60120
ELMHURST
Haven Clinical Lab. (ABCD)
103 Haven Rd., 60126
Sandahl Medical Labs. (ABCDE)
135 S. Kenilworth, 60126
EVANSTON
COS Building Lab. (H)
2500 Ridge Ave., 60201
Gyne Cytology Lab., Inc (G)
636 Church St., 60201
Pathology Associates (H)
636 Church St., 60201
EVERGREEN PARK
Anatomic & Clinical Pathology Lab. (G)
P. O. Box 919, 60642
FOREST PARK
Bowers Lab. (ABCDE)
7450 Jackson Blvd., 60130
FRANKLIN PARK
Franklin Park Medical Lab. (CDEFG)
9711 Grand, 60131
GALESBURG
Galesburg Clinic Lab. (ABCDE)
320 N. Kellogg, 61401
Medical Lab. (H)
628 Bondi Bldg., 61401
GLENVIEW
NW Sub X-Ray & Clinical Lab. (ABCDE)
924 Waukegan, 60025
HARVEY
Graham Clinical Lab. (BC)
468 E. 147th St., 60426
HIGHLAND PARK
Highland Park Medical Lab. (ABCDE)
1950 Sheridan Rd., 60035
HINSDALE
Pathology Associates (H)
40 S. Clay, 60521
HOFFMAN ESTATES
Twinbrook Medical Lab., Inc. (ABD)
Golf & Roselle Rds., 60172
JOLIET
Associated Pathologists (G)
2112 W. Jefferson St. 60435
Central Lab. (ABCDE)
57 W. Jefferson St., 60431
Osler Labs., Inc. (CD)
120 N. Scott St., 60431
Prescription Shop Lab., (ABCE)
56 N. Chicago, 60431
Woodruff Lab., Inc. (ABCD)
250 N. Ottawa St., 60431
KANKAKEE
Medical Center Lab. (ABCDE)
1309 E. Court, 60901
LA GRANGE
La Grange Medical Building Lab. (BCDE)
47 S. Sixth Ave., 60525
LANSING
De Graff Clinical Lab. (ABCDE)
3341 Ridge Rd., 60438
LA SALLE
Medical Lab. (ABCDE)
555 2nd St., 61301
MAYWOOD
Josyln Clinic Lab. (ABCDE)
1908 St. Charles Rd., 60153
McHENRY
McHenry Medical Group (H)
1110 N. Green St., 60050
MELROSE PARK
Delm Clinical Lab. (ABCDE)
1900 W. Iowa 60160
MOLINE
Martin Clinical Lab. (H)
1520 7th St., 61265
MORTON GROVE
Sommerfeld Med. Lab. (ABCD)
5818 Dempster St. 60003
MOUNT PROSPECT
Mt. Prospect Clinical Lab. (ACDE)
321 W. Prospect, 60056
Prospect Clinical Lab. (ABCD)
1060 W. Northwest Hwy, 60056
NORTHBROOK
Northbrook Cl. & X-Ray Labs. (ABCD)
1775 Walters, 60062
OAK BROOK
Pathology Associates (H)
120 Oak Brook Ctr. Ml., 60521
OAK PARK
American Medical Lab. (BCD)
6441 W. North Ave., 60302
Arms Medical Lab. (CD)
414 S. Oak Park Ave. 60302
Hill Clinical Lab. (H)
1011 Lake St., 60301
James B. Hartney, M.D. (FG)
410 Lake St., 60302
Mac Gregor Lab. (BCDE)
6144 W. Roosevelt Rd. 60304
North Riverside Medical Lab., Inc. (ABCDE)
1159 Westgate, 60301
Twin Oaks Lab. (ABCDE)
101 W. Madison St., 60304
OGLESBY
Physicians Clinical Lab. (CD)
338 E. Walnut St., 61348
PALOS HEIGHTS
Palos Medical Lab. (ABCDE)
12150 S. Harlem, 60463
PEKIN
The Medical Lab. (ABCDE)
519 Margaret, 61554
PEORIA
M B Clinical Lab. (ABCDE)
818 Main Street, 61606
Medical Center Labs. (H)
416 St. Marks Ct., 61603

Wm. Schwarzendruber Lab. (ABCD)
300 E. War Mem. Dr., 61614

ROCKFORD
Medical Labs. of Pathology (H)
1221 E. State St., 61108

SKOKIE
Dempster Street Pathology Lab. (BDFG)
4240 Dempster, 60076
Lincoln Medical Lab. (CD)
4535 Oakton, 60076
North Sub. Clinical Lab. (ABCDE)
4801 Church St., 60076
Pasco Medical Lab. (BCDG)
64 Old Orchard 60076

SPRINGFIELD
Capitol Clinical Labs. (ABCDE)
1104 S. Second, 62704
Physicians Medical Lab. (ABCDE)
501 N. 6th St., 62705
Springfield Clinical Lab. (ABCD)
1025 S. 7th St. 62703

Ardmore Pharmacy Inc. (BCD)
317 S. Ardmore Ave. 60181

WAUKEGAN
Besley-Waukegan Clinic (ABCDE)
215 N. Sheridan Rd., 60085
Physicians & Surgeons Lab. (H)
1616 W. Grand, 60085

WHEATON
Drs. Mason & Barron (H)
200 E. Willow 60187

WILMETTE
Wilmette Clinical Lab. (H)
165 Green Bay Rd., 60091

WINNETKA
Clini-Tech Labs., Inc. (ABCD)
1048 Gage St., 60093
Winnetka Clinical Lab. (ABCDE)
725 Elm St., 60093

ZION
Zion Clinic Lab (CDE)
2629 Sheridan Rd., 60099

ARTIFICIAL KIDNEY CENTERS

As of May 1, 1968, these centers may be contacted regarding renal dialysis.

Children's Memorial Hospital	Phone:	348-4040
2300 Children's Plaza	Person in Charge:	Alan Siegel, M.D.
Chicago	Location in Hosp:	Nephrology
Edgewater Hospital	Phone:	UP 8-6000
5700 N. Ashland Avenue	Person in Charge:	Rogelio Riera, M.D.
Chicago	Location in Hosp:	Surgery
Michael Reese Hospital	Phone:	225-5525
2929 South Ellis Avenue	Person in Charge:	Dr. Allan Kanter
Chicago	Location in Hosp:	Department of Medicine Division of Renal Medicine
Mt. Sinai Hospital	Phone:	277-4000
California Ave. at 15th Street	Person in Charge:	Dr. George Dunea
Chicago	Location in Hosp:	Department of Medicine
Passavant Memorial Hospital	Phone:	WH 4-4200
303 E. Superior Street	Person in Charge:	Francesco del Greco, M.D.
Chicago	Location in Hosp:	Artificial Kidney
Presbyterian-St. Lukes Hospital	Phone:	738-4411
1753 West Congress Parkway	Person in Charge:	Robert M. Kark, M.D.
Chicago	Location in Hosp:	Division of Medicine
University of Chicago Hospital	Phone:	MU 4-6100
950 E. 59th Street	Person in Charge:	Dr. Marvin Forland
Chicago	Location in Hosp:	Department of Medicine
University of Illinois Research and Educational Hospital	Phone:	663-7591
840 South Wood Street	Person in Charge:	Clarence Gantt, M.D.
Chicago	Location in Hosp:	Clinical Research Center
St. Joseph Hospital	Phone:	741-5400
277 Jefferson Avenue	Person in Charge:	Charles K. Bobelis, M.D.
Elgin	Location in Hosp:	Artificial Kidney Dept.

Evanston Hospital 2650 Ridge Avenue Evanston	Phone: 492-2000 Person in Charge: Location in Hosp:	 Dr. Bernard Adelson Kidney Dialysis Dept.
Riverside Hospital 350 N. Wall Kankakee	Phone: 933-1671 Person in Charge: Location in Hosp:	 Dr. Eugene Anderson Intensive Care

Presently available for acute poisoning cases only

West Suburban Hospital 518 North Austin Boulevard Oak Park	Phone: EU 3-6200 Person in Charge: Location in Hosp:	 Robert Muehrcke, M.D. Kidney Dialysis Room-2nd Fl.
St. Francis Hospital 530 N.E. Glen Oak Peoria	Phone: 674-7731 Person in Charge: Location in Hosp:	Ext. 605 Dr. J. D. Myers Chronic Dialysis Unit
Swedish-American Hospital 1316 Charles Street Rockford	Phone: 968-6898 Person in Charge: Location in Hosp:	 Dr. John Berry Intensive Care
Memorial Hospital First & Miller Streets Springfield	Phone 528-2041 Person in Charge: Location in Hosp:	 Antonio Versaci, M.D. Intensive Care
St. John's Hospital 701 E. Mason Street Springfield	Phone: 544-4451 Person in charge: Sister M. Jane	

HOME HEALTH AGENCIES CERTIFIED UNDER TITLE 18 (MEDICARE) AUGUST 1, 1968

In addition to providing skilled nursing service, Home Health Agencies are certified for providing the following specific secondary services:

M.S.S.—Medical Social Services
SP.T.—Speech Therapy
P.T.—Physical Therapy
O.T.—Occupational Therapy
H.H.A.—Home Health Aide Service

ALEDO

Mercer County Health Department
Court House, Aledo 61231
P.O.—O.T.—Sp.T.

ALTON

Family Service and Visiting Nurse Assn.
211 E. Broadway Alton 62002
M.S.S.

AURORA

Visiting Nurse Association of Aurora
320 N. Lake St. 60506
Sp.T.

BELLWOOD

Community Nursing Service of Proviso Township
233 Mannheim Rd., Bellewood 60104
P.T.

CAIRO

Tri County Health Department
1115 Cedar St., Cairo 62914
Sp.T.

CAMBRIDGE

Henry County Health Department
Court House Annex, Cambridge 61238
P.T.

CANTON

Fulton County Health Department
31 S. Main St., Canton 61520
P.T.

CHAMPAIGN

Champaign-Urbana Public Health District
505 S. Fifth St., Champaign 61820
P.T.

CHARLESTON

Charleston Community Memorial Hospital
Rt. 130, Charleston 61920
P.T.

CHICAGO

Alverna Home Nursing Center
1437 W. 51st St., Chicago 60609
P.T.

Babette & Emanuel Mandel Clinic
508 E. 29th St., Chicago 60616
P.T.—O.T.—M.S.S.

Cook County Dept. of Public Health
1425 S. Racine Ave., Chicago 60608
P.T.

Drexel Home Inc.
6140 S. Drexel Ave., Chicago 60637
P.T.—O.T.—M.S.S.—H.H.A.

Jewish Home For Aged
1648 S. Albany Ave., Chicago 60623
P.T.—O.T.—Sp.T.—M.S.S.—H.H.A.

Mt. Sinai Hospital Medical Center
California Ave & 15th St., Chicago 60608
P.T.—O.T.—Sp.T.—M.S.S.

Park View Home
1401 California Ave., Chicago 60622
P.T.—O.T.—Sp.T.—M.S.S.—H.H.A.

V. N. A. of Chicago
5 S. Wabash Ave., Chicago 60603
P.T.—Sp.T.—M.S.S.—H.H.A.

CLINTON

DeWitt-Piatt Bi-County Health Unit
122 E. Main St., Clinton 61727
Sp.T.

DANVILLE

Child Welfare and Visiting Nurse Association Inc.
402 N. Hazel St., Danville 61832
M.S.S.—P.T.

Vermilion County Health Department
808 N. Logan Ave., Danville 61832
M.S.S.

DECATUR

Visiting Nurse Association of Macon County
1891 North Water St., Decatur 62523
P.T.—O.T.—H.H.A.

DeKALB

DeKalb County Health Department
1731 Sycamore Rd., DeKalb 60115
P.T.—Sp.T.

DES PLAINES

Des Plaines Dept. of Public Health
City Hall, Des Plaines 60016
P.T.—Sp.T.

DIXON

Lee County Health Department
316 W. Third St., Dixon 61021
Sp.T.

EAST MOLINE

East Moline Visiting Nurse Association
915—16th Ave., East Moline 61244
P.T.—Sp.T.—O.T.

EAST ST. LOUIS

Visiting Nurse Assoc. of St. Clair County
4601 State St., East St. Louis 62205
P.T.—O.T.—Sp.T.—H.H.A.

EFFINGHAM

Effingham County Health Department
112 E. Section Ave., Effingham 62401
P.T.

ELDORADO

Egyptian Health Department
1333 Locust St., Eldorado 62930
Sp.T.

ELGIN

Elgin Health Center
370 E. Chicago St., Elgin 60120
P.T.

EVANSTON

Visiting Nurse Association of Evanston
828 Davis St., Evanston 60201
P.T.—Sp.T.—H.H.A.

FLORA

Clay County Health Dept.
104½ W. Second St., Flora 62839
M.S.S.

FREEPORT

Stephenson County Health Dept.
12 N. Galena Rd., Freeport 61032
Sp.T.

Visiting Nurse Assoc. of Amity Societies
7 N. State St., Freeport 61032
P.T.

GALENA

Jo Daviess County Health Department
311 S. Main St., Galena 61036
P.T.

GOLCONDA

Quadri-County Health Department
Golconda 62938
P.T.—O.T.—Sp.T.

GREENVILLE

Bond County Health Department
100 N. Locust St., Greenville 62246
P.T.

HARDIN

Calhoun County Health Department
Sweeney Professional Bldg., Hardin 62047
P.T.

HIGHLAND PARK

Visiting Nurse Association of Deerfield Township
718 Glenview Ave., Highland Park 60035
P.T.

JACKSONVILLE

Morgan County Health Dept. & Visiting Nurse Association
234½ W. State St., Jacksonville 62650
P.T.

JERSEYVILLE
Jersey County Health Department
Courthouse, Jerseyville 62052
P.T.

JOHNSTON CITY
Franklin—Williamson Bi-County Health Dept.
217 E. Broadway, Johnston City 62951
P.T.

JOLIET
Public Health Council
102½ E. Van Buren St. Joilet 60432
P.T.
Will County Health Department
21 E. Van Buren, Joilet 60435
P.T.

LaSALLE
Hygienic Institute
151 Fifth St., LaSalle 61301
P.T.

LAKE FOREST
Lake Forest Hospital Home Care Patients
660 N. Westmoreland Rd., Lake Forest 60045
P.T.

LAWRENCEVILLE
Lawrence County Health Department
Courthouse, Lawrenceville 62439
P.T.

LINCOLN
Abraham Lincoln Memorial Home Health Serv.
315 Eighth St., Lincoln 62656
P.T.—Sp.T.

MARSEILLES
Marseilles Nursing Service
227 S. Main St., Marseilles 61341
P.T.

McHENRY
McHenry County Health Department
605 N. Green St., Woodstock 60050
P.T.

MOLINE
Moline Visiting Nurse Association
1409—7th Ave., Moline 61265
P.T.—O.T.—Sp.T.

MORRIS
Grundy County Health Department
Courthouse, Morris 60450
P.T.

MOUNT CARROLL
Carroll County Health Department
Courthouse, Mount Carroll 61053
P.T.

MURPHYSBORO
Jackson County Health Department
1015½ Chestnut St., Murphysboro 62966
Sp.T.

OAK LAWN
Stickney Public Health District
5636 State Rd., Oak Lawn 60459
M.S.S.

OAK PARK
Community Nursing Service of Oak Park & River Forest
124 S. Marion St., Oak Park 60302
P.T.—Sp.T.—O.T.—H.H.A.

OREGON
Ogle County Health Department
106 S. 5th St., Oregon 61061
P.T.

OTTAWA
Ottawa Public Health Nursing Assn.
417 W. Madison St., Ottawa 61350
P.T.

PARK FOREST
Park Forest Public Health Nursing Service
Village Hall, 200 F B, Park Forest 60466
H.H.A.

PEKIN
Home Care Program Pekin Memorial Hospital
Corner of Court & 14th St., Pekin 61554
H.H.A.

PEORIA
Peoria County Health Department
2114 N. Sheridan Rd., Peoria 61604
P.T.—Sp.T.—O.T.—M.S.S.
Visiting Nurse Assn. of Peoria and Peoria NPC
510 W. High St., Peoria 61606
H.H.A.—O.T.—P.T.—M.S.S.

PETERSBURG
Menard County Health Department
Courthouse, Petersburg 62675
Sp.T.

PITTSFIELD
Pike County Health Department
Courthouse, Pittsfield 62363
P.T.

PONTIAC
Livingston County Public Health Dept.
419 Bank of Pontiac Bldg., Pontiac 61764
P.T.

PRINCETON
Bureau County Health Department
Hotel Clark, Princeton 61356
Sp. T.

QUINCY
Adams County Health Department
333 N. Sixth St., Quincy 62301
P.T.—M.S.S.

ROCK FALLS
Whiteside County Board of Health
201 W. First St., Rock Falls 61071
P.T.

ROCK ISLAND
Rock Island Co. Dept. of Health
County Courthouse, Rock Island 61201
P.T.—Sp.T.—O.T.
Rock Island Visiting Nurse Association
1019—27th Ave., Rock Island 61201
P.T.—Sp.T.—O.T.

ROCKFORD
Visiting Nurses Association of Rockford
703 Grove St., Rockford 61108
P.T.

SHELBYVILLE
Shelby County Health Department
123 N. Broadway, Shelbyville 62565
Sp.T.—P.T.

SILVIS
Silvis-Carbon Cliff Visiting Nurse Assn.
1040 First Ave., Silvis 61282
P.T.—Sp.T.—O.T.

SKOKIE
Skokie Health Department
5127 Oakton St., Skokie 60076
P.T.
Visiting Nurse Assn., of Skokie Valley
5255 Main St., Skokie 60076
P.T.—Sp.T.—H.H.A.

SPARTA
Randolph County Health Department
112 W. Jackson St., Sparta 62286
P.T.

SPRINGFIELD
Visiting Nurse Assn. of Sangamon County
730 E. Vine St., Springfield 62703
P.T.

TAYLORVILLE
Christian County Health Department
106 E. Main St., Taylorville 62568
P.T.—Sp.T.

TUSCOLA
Douglas County Health Department
705 N. Main St., Tuscola 61953
P.T.

WATSEKA
The Iroquois Hospital
200 Fairman St., Watseka 60970
P.T.—Sp.T.

WAUKEGAN
Community Nursing Service of Lake County, Inc.
1515 Washington St. Waukegan 60085
P.T.

WHEATON
DuPage County Health Dept. & Nursing Service
222 E. Willow, Wheaton 60188
P.T.—H.H.A.

WILMETTE
Wilmette Visiting Nurse Ass'n.
905 Ridge Rd., Wilmette 60091
P.T.—H.H.A.

WINNETKA
North Shore Visiting Nurse Ass'n
614 Lincoln Ave., Winnetka 60093
P.T.

WOODSTOCK
McHenry County Dept., Public Health
209 N. Benton St., Woodstock 60050
P.T.

YORKVILLE
Kendall County Health Department
County Courthouse, Yorkville 60560
P.T.

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
2020 W. Odgen Ave.
Chicago, Ill. 60612
Leroy Levitt, M.D., Dean
226-4100

University of Chicago Pritzker School of Medicine
950 E. 59th St.
Chicago, Ill. 60637
Leon Jacobson, M.D., Dean
MU 4-6100
MU 3-0800

Northwestern University Medical School
710 N. Lake Shore Dr.
Chicago, Ill. 60611
Richard H. Young, M.D., Dean
649-8649

University of Illinois College of Medicine
1853 W. Polk St.
P.O. Box 6998
Chicago, Ill. 60680
William Grove, M.D., Dean
663-7000

Stritch School of Medicine—Loyola University
1400 S. First Ave., Hines, Ill. 60141
921-2610
John F. Sheehan, M.D., Dean
706 S. Wolcott Ave.
Chicago, Ill. 60612
SE 3-8040

APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community Hospital
AURORA—Copley Memorial Hospital
St. Joseph Mercy Hospital
BLOOMINGTON—Bloomington-Normal Hospital
BLUE ISLAND—St. Francis Hospital
CENTRALIA—St. Mary's Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Chicago Wesley Memorial Hospital
Cook County Graduate School of Medicine
Edgewater Hospital
Englewood Hospital
Evangelical Hospital
Franklin Boulevard Community Hospital
Grant Hospital
Henrotin Hospital
Illinois Masonic Hospital
Louis A. Weiss Memorial Hospital
Lutheran Deaconess Hospital
Michael Reese Hospital
Mt. Sinai Hospital
Norwegian-American Hospital
Presbyterian-St. Luke's Hospital
Provident Hospital
Ravenswood Hospital
Roseland Community Hospital
St. Anne's Hospital
St. Bernard's Hospital
St. Elizabeth's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital
South Chicago Community Hospital
Woodlawn Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur and Macon County Hospital
DIXON—Dixon Public Hospital
EAST ST. LOUIS—Centreville Township Hospital
ELMHURST—Memorial Hospital of DuPage County
EVANSTON—St. Francis Hospital
EVERGREEN PARK—Little Company of Mary Hospital
GREAT LAKES—U.S. Naval Hospital
HARVEY—Ingalls Memorial Hospital
HINSDALE—Hinsdale Sanitarium and Hospital
JOLIET—Silver Cross Hospital
KANKAKEE—St. Mary's Hospital
KEWANEE—Kewanee Public Hospital
MOLINE—Luthern Hospital
Moline Public Hospital
OAK PARK—West Suburban Hospital
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Hospital of Central Illinois
St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital
Swedish-American Hospital
ROCK ISLAND—St. Anthony's Hospital
SKOKIE—Skokie Valley Community Hospital
SPRINGFIELD—Memorial Hospital
St. John's Hospital
URBANA—Carle Memorial Hospital
Mercy Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Hospital and Medical Center
Mount Sinai Hospital Medical Center
University of Chicago Hospitals and Clinics
EVANSTON—Evanston Hospital
St. Francis Hospital
EVERGREEN PARK—Little Company of Mary Hospital
FREEPORT—Freeport Memorial Hospital
GENEVA—Community Hospital
HARVEY—Ingalls Memorial Hospital
HINSDALE—Hinsdale Sanitarium and Hospital
JOLIET—Silver Cross Hospital
St. Joseph Hospital
MOLINE—Moline Public Hospital
OAK LAWN—Christ Community Hospital
OAK PARK—West Suburban Hospital
PEORIA—Methodist Hospital, Proctor Community Hospital and St. Francis Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital
ROCK ISLAND—St. Anthony Hospital
SPRINGFIELD—Memorial Hospital
St. John's Hospital
URBANA—Carle Foundation
WAUKEGAN—St. Therese's Hospital
WINFIELD—Central Dupage Hospital

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Alexian Brothers Hospital, Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Hospital, Louis A. Weiss Memorial Hospital, Michael Reese Hospital, Mount Sinai Hospital, Northwestern University Medical School, (Passavant Memorial Hospital), Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony de-Padua Hospital, St. Bernard's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of Associated Medical Sciences and Veterans Administration Research Hospital.
CHICAGO HEIGHTS—St. James Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur and Macon County Hospital and St. Mary's Hospital

APPROVED SCHOOLS FOR MEDICAL RECORD LIBRARIANS

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, University of Chicago Hospitals
MELROSE PARK—Gottlieb Memorial Hospital
MOLINE—Lutheran Hospital
SPRINGFIELD—Memorial Hospital, St. John's Hospital

APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois College of Medicine

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital
CHICAGO—St. Elizabeth's Hospital, Swedish Covenant Hospital and Veterans Administration West Side Hospital.
DANVILLE—St. Elizabeth Hospital
DIXON—Dixon Public Hospital
ELGIN—Sherman Hospital
EVERGREEN PARK—Little Company of Mary Hospital
OAK PARK—Oak Park Hospital
QUINCY—Blessing Hospital

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

General Entrance Requirements:

Good health.
High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).
Qualification for admission to the college and the nursing curriculum.
Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.
Living Arrangements: students live at home, in a college dormitory or other approved residence.
Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

BELLEVILLE
Belleville Junior College
Department of Nursing
2250 West Blvd. 62221

CHICAGO
Amundsen-Mayfair Junior College
Department of Nursing
4626 N. Knox Ave. 60630

Crane College School of Nursing
2250 W. VanBuren 60612
Southeast College School of Nursing
8600 South Anthony 60617

CHICAGO HEIGHTS
Prairie State College
Department of Nursing
10th & Dixie Highway 60411

CHAMPAIGN
Parkland College School of Nursing
2 Main Street 61820

CICERO
J. Sterling Morton Junior College
Department of Nursing
2423 S. Austin Blvd. 60650

DIXON
Sauk Valley College School of Nursing
River Campus, R.R. #1 61021

EAST PEORIA
Illinois Central College School of Nursing
Highview Road,
P. O. Box 2400 61611

ELGIN
Elgin Community College
Department of Nursing
373 E. Chicago St. 60120

HARVEY
Thornton Junior College
Department of Nursing
151st St. & Broadway 60164

LaSALLE
Illinois Valley Community College
Associate Degree Nursing Program
Fifth and Chartres 61301

MOLINE
Black Hawk College
Department of Nursing
1001 Sixteenth St. 61265

NORTHLAKE
Triton College
Department of Nursing
1000 Wolf Rd. 60164

PALATINE
Harper College Associate Degree
Nursing Program
34 W. Palatine Rd. 60067

ROCKFORD
Rock Valley College
Associate Degree Nursing Program
3301 N. Mulford Rd. 61111

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately $1,000 to $7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

BLOOMINGTON
Illinois Wesleyan University
Brokaw Collegiate School of
Nursing 61701

CHICAGO
DePaul University
Department of Nursing
25 E. Jackson Blvd. 60604
Loyola University
School of Nursing
6526 N. Sheridan Rd. 60626
North Park College
Department of Nursing
5125 N. Spaulding Ave. 60625
St. Xavier College
School of Nursing
103rd & Central Park 60655
University of Illinois
College of Nursing
808 S. Wood St. 60612

DEKALB
Northern Illinois University
School of Nursing 60115

EDWARDSVILLE
Southern Illinois University
Department of Nursing 62025

KANKAKEE
Olivet Nazarene College
Department of Nursing 60901

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: $900 to $3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

ALTON
Alton Memorial Hospital
Memorial Drive 62004
St. Joseph's Hospital
915 E. Fifth St. 62004

AURORA
Copley Memorial Hospital
Lincoln & Weston 60507

BLOOMINGTON
Mennonite Hospital
804 N. East St. 61701

CANTON
Graham Hospital
210 W. Walnut St. 61520

CHAMPAIGN
Julia F. Burnham—
Burnham City Hospital
404 S. Third St. 61822

CHICAGO
Augustana Hospital
411 Dickens Ave. 60614
Chicago Wesley Memorial Hospital
250 E. Superior St. 60611
Columbus Hospital
2520 Lakeview Ave. 60614
Cook County
1900 W. Polk St. 60612
Hospital of St. Anthony dePadua
2875 W. 19th St. 60623
Illinois Masonic Hospital
836 Wellington Ave. 60657
James Ward Thorne—
Passavant Memorial Hospital
244 East Pearson St. 60611
Michael Reese Hospital and Medical Center
2816 S. Ellis Ave. 60616
Mount Sinai Hospital Medical Center
2730 W. 15th Place 60608
Ravenswood Hospital
1931 W. Wilson Ave. 60640
Roseland Community Hospital
45 W. 111th Ave. 60628
St. Anne's Hospital
4980 W. Thomas 60651
St. Bernard's Hospital
6344 S. Harvard Ave. 60621
St. Elizabeth's Hospital
1431 N. Claremont Ave. 60622
St. Mary of Nazareth Hospital
1127 N. Oakley Blvd. 60622
South Chicago Community Hospital
2320 E. 93rd St. 60617

DANVILLE
Lake View Memorial Hospital
812 N. Logan Ave. 61833

DECATUR
Decatur and Macon County Hospital
2300 N. Edward St. 62526

EVANSTON
Evanston Hospital
2645 Girard Ave. 60201
St. Francis Hospital
319 Ridge Ave. 60202

EVERGREEN PARK
Little Company of Mary Hospital
2800 W. 95th St. 60642

FREEPORT
Freeport Memorial Hospital
1335 W. Stephenson 61032

GALESBURG
Galesburg Cottage Hospital
674 N. Seminary Ave. 61401

JACKSONVILLE
Passavant Memorial Area Hospital
1600 W. Walnut St. 62650

JOLIET
St. Joseph's Hospital
333 N. Madison St. 60435
Silver Cross Hospital
600 Walnut St. 60432

MOLINE
Lutheran Hospital
555 Sixth St. 61265
Moline Public Hospital
622 Fifth Ave. 61265

OAK LAWN
Evangelical (Christ Community Hospital)
4540 S. Morgan

OAK PARK
Oak Park Hospital
500 S. Maple Ave. 60304
West Suburban Hospital
518 N. Austin Blvd. 60302

PARK RIDGE
Lutheran General and Deaconness Hospitals
1700 Western Ave. 60068

PEORIA
Methodist Hospital of Central Illinois
221 N.E. Glen Oak 61603
St. Francis Hospital
211 Greenleaf St. 61603

QUINCY
Blessing Hospital
1005 Broadway 62301

ROCKFORD
Rockford Memorial Hospital
2400 N. Rockton Ave. 61101
St. Anthony's Hospital
1411 E. State St. 61108
Swedish-American Hospital
1316 Charles St. 61101

ROCK ISLAND
St. Anthony's Hospital
767 Thirtieth St. 61201

SPRINGFIELD
Memorial Hospital
200 W. Dodge St. 62701
St. John's Hospital
821 E. Mason St. 62701

URBANA
Mercy Hospital
1405 W. Park St. 61801

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

Entrance Requirements:

Good health.
High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.
Satisfactory results on entrance tests.
References and personal interview.

Cost: None under MDTA programs, to approximately $400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

ALTON
F. W. Olin School of Practical Nursing
2200 College Ave. 62002

BLOOMINGTON
Bloomington School of Practical Nursing
709 S. Clinton St. 61701

CAIRO
Cairo School of Practical Nursing
1615 Commercial Street 62914

CARBONDALE
Southern Illinois University Vocational Public Technical Institute of Practical Nursing, Manpower Division (MDTA) 62901

CHAMPAIGN
Champaign School of Practical Nursing
103 N. Prospect Ave. 61820

CHICAGO
Chicago Public Schools Practical Nursing Program, Chicago Board of Education
1820 W. Grenshaw 60612
Practical Nurses Training Program, Chicago Board of Education, Manpower Division (MDTA)
2913 N. Commonwealth 60657
St. Frances X. Cabrini School of Practical Nursing
811 S. Lytle St. 60607

DANVILLE
Danville Junior College School of Practical Nursing
305 W. Madison St. 61833

DECATUR
Decatur School of Practical Nursing
210 W. North St. 62523

DIXON
Sauk Valley College
Rural Route No. 1 61021

EAST PEKIN
Pekin Practical Nurse Program
Pekin Community High School 61554

EAST ST. LOUIS
Board of Education District 189
School of Practical Nursing
332 N. Ninth 62201

GALESBURG
Galesburg Practical Nurse Program
650 Locust St. 61401

HARRISBURG
Southeastern Illinois College School of Practical Nursing
333 W. College St. 62946

HINSDALE
Hinsdale Sanitarium and Hospital School of Practical Nursing
120 N. Oak St. 60521

JACKSONVILLE
Jacksonville Board of Education School of Practical Nursing
504 E. Court St. 62650

JOLIET
Joliet Township H.S. School of Practical Nursing
201 E. Jefferson St. 60432

KANKAKEE
Kankakee School of Practical Nursing
293 E. Court St. 60901

LASALLE
St. Mary's Hospital School of Practical Nursing
1015 O'Connor St. 61301

MATTOON
Lakeland Community College
School of Practical Nursing
1921 Richmond 61938

MT. CARMEL
Wabash Valley College Practical Nursing Program
2222 College Dr. 62863

MT. VERNON
Rend Lake College
School of Practical Nursing
315 South 7th 62864

NORTHLAKE
Triton Junior College
Practical Nursing Program
1000 Wolf Road 60164

OAK FOREST
Oak Forest Hospital School of Practical Nursing
15900 S. Cicero 60452

PEORIA
Peoria School of Practical Nursing
609 W. High St. 61606

QUINCY
Quincy School of Practical Nursing
1200 Main St. 62301

ROCK ISLAND
Blackhawk College School of Practical Nursing
2122 Twenty-fifth Ave. 61201

ROCKFORD
Rockford School of Practical Nursing
201 S. Madison 61101

SKOKIE
Niles Township H.S. School of Practical Nursing
Oakton and Edens Expressway 60018

SPRINGFIELD
Springfield School of Practical Nursing
1300 S. Sixth St. 62704

STREATOR
Streator Township High School
Practical Nursing Program
600 N. Jefferson 61364

WAUKEGAN
Waukegan Township High School Practical Nurse Program
1011 Washington St. 60089

DEPARTMENT OF REGISTRATION AND EDUCATION

John C. Watson, *Director*
John B. Hayes, *Superintendent of Registration*
Ira T. Dawson, *Assistant Director*
Joel E. Gimpel, *Technical Advisor, Division of Professional Supervision*

The department is primarily concerned with the registration, licensing and enforcement of 31 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the newly created Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration headed by the Superintendent of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

William Johnson, M.D., Galesburg
Dale E. Richardson, D.O., Pontiac
Kenneth H. Schnepp, M.D., Springfield
Warren D. Tuttle, M.D., Harrisburg
Robert R. Walper, D.C., Chicago

Medical Practice Act

Licensing and Enforcement Procedures

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no persons shall practice medicine or any of its branches or midwifery, or any system or method of treating human ailments without the use of drugs or medicines, or without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

Required Education

Minimum standards of professional education: 2 years' course of instruction in a college of liberal arts or its equivalent, or in such medical college in a course of instruction in the treatment of human ailments which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months and in addition, a course of clinical training of not less than 12 months in a hospital. The college of liberal arts, medical school, and hospital must be reputable and in good standing in the judgment of the Department of Registration and Education.

All examinations provided by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches which shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of $10.

Revocation and Suspension of License or Certificate

The department may revoke or suspend the license, certificate, or state hospital permit of any person licensed under the act upon any of the following grounds:

"1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court.
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, or to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules

and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state.
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

Rule 1—Accredited Colleges of Medicine and Surgery

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

Rule II—Accredited Colleges Teaching Systems of Treating Human Ailments Without the Use of Drugs or Medicine and Without Operative Surgery.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy
  (a) Embryology
  (b) Histology
  (c) Neuro-anatomy
(2) Physiology and Chemistry
(3) Pathology and Bacteriology
(4) Diagnosis
  (a) Physical
  (b) Differential
  (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, pathology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all

students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

Rule III—Hospitals Approved for Internship.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

Rule IV—Application for Examination

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and the two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph Ib or Section 13, may apply for the examination or

clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating interships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

THEORETICAL

Chemistry
Physiology
Anatomy
Pharmacology
Pathology
Bacteriology
Medicine
Public Health & Preventive Medicine
Obstetrics & Gynecology
Surgery
Pediatrics
Psychiatry

CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

THEORETICAL

Chemistry & Physiology
Anatomy & Histology
Pathology & Bacteriology
Diagnosis
Hygiene & Medical Jurisprudence
Eye, Ear, Nose, & Throat
Dermatology, Pediatrics & Neurology
System of Practice
Obstetrics (of graduates of approved osteopathic colleges)

PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75 has been received in that part of the examination.

5. Applicants who take the regular examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

Rule VI—Reciprocity

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

Rule VII—Licensure

1. An examinate who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

Rule VIII—Tempory Certificates of Registration

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the ap-

proved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The Department shall not accept any application for a Temporary Certificate of Registration on behalf of an applicant who has a pending application on file to take the Department examination for a license to practice medicine in all its branches in the State of Illinois, or an applicant who has previously taken and failed such Department examination.

11. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(Section 24 *Medical Practice Act.* [Chp. 91, Sec. 16i, *1967 Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action re-

sulting in revocation or suspenson of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

   A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Chiropody-Podiatry Examining Committee

Dr. Charles H. Delano
Dr. Theodore S. Hollingsworth

Dental Examining Committee

Dr. Eugene E. Ausbrook
Dr. Hugh D. Burke
Dr. Ralph H. Council
Dr. Herbert C. Gustavson
Dr. Peyton Sidney Neuwirth
Dr. Adrian L. Swanson
Dr. William O. Vopata

Committee of Nurse Examiners

Eleanor Maria Carlson
Sister M. Francis, O.S.F.
Dona Herbst
Dr. Annette Lefkowitz
Marion Lennan

Optometry Examining Committee

Wayne B. Cox, O.D.
Stanley Engelhardt, O.D.
James K. Finley, O.D.
Thomas M. McGuire, O.D.
Clarence J. Strobel, O.D.

Pharmacy Examining Committee

Milton G. Christy
Joseph Davidson
Dr. James E. Gearien
Aloysius J. Niezgodski
Harold W. Pratt
Benjamin B. Rosen
David W. Watt

Physical Therapy Examining Committee

James Mason Gray
Mildred F. Andrews
Vilma Evans

Psychologist Examining Committee

Dr. Philip Ash
Dr. Roy Brener
Dr. Carl Duncan
Dr. Leroy A. Wauk



Medical Legal Information

LEGAL SERVICES OF ISMS

The Illinois State Medical Society retains a General counsel and occasionally uses the services of special counsel in implementing its various programs. Legal advice is given to the state society and its components as organizations, but is not available to individual members.

It is intended that this article give general information only; for any specific problem consultation should be had with the physician's individual attorney.

The legal department of the Society can answer specific questions propounded by officers of county medical societies in Illinois, which are part of and make up the state society, if the questions are of interest to the membership as a whole.

Although the Society and its counsel cannot provide personal advice to ISMS members, it is to every physician's advantage to acquaint himself with as much general medical-legal knowledge as possible. The following section, therefore, is devoted to this kind of information.

HOW TO SET YOUR AFFAIRS IN ORDER

A physician's death, expected or not, often creates burdensome tasks for survivors. Natural grief is complicated by the necessity for rapid decisions and hurried searches for required information. Significant papers may be so well put away that prolonged seeking in various places may be required, with added pain for the bereaved.

It is therefore suggested that the physician, during his lifetime, ease the situation by compiling in one place needed information about the location of important records and papers. In addition, the Illinois State Medical Society urges each member to have a will prepared by a competent attorney and to have the said will re-evaluated by an attorney whenever there is a material change in any of his circumstances or in the law of his state.

The executor named in the will can handle the doctor's estate most efficiently if he has access to specific information.

The physician should, of course, leave information about insurance, real estate, and bank accounts just as everyone else does, but he has additional responsibilities peculiar to his profession. He should leave instructions for:

1. Temporary coverage of his practice. Some arrangement with a colleague should be made immediately for hospitalized patients, and others should be notified of the doctor's death.

2. Patient records, which should be carefully preserved for a minimum of 10 years and for 25 years, if possible. Contents of the records should be turned over to another physician upon written request.

3. Return of unused narcotics to the Treasury Department, the narcotics tax stamp and order book to the Internal Revenue Service, and retention of the narcotics ledger for two years.

4. Disposal of his practice. If it is to be sold, rapid action is advised as value is lost quickly. Equipment is best disposed of with the sale of the practice.

5. Benefits that may be due survivors from unused insurance premiums, Blue Cross-Blue Shield, Veterans Administration, or Social Security.

As soon as practical after death, the attorney who will handle the estate should be contacted and his advice followed thereafter.

LEGAL LIABILITY OF PHYSICIANS

The legal liability of physicians is a question on which much has been written. It has also been the topic of discussion at many meetings of medical and medical-legal groups. However, because of the grave nature of the problem, the Illinois State Medical Society's legal counsel believes that the subject cannot be overemphasized.

Statistics prove that the number of malpractice and general liability suits against physicians is on the increase. This does not mean that physicians are becoming less skillful or more careless in their diagnosis and treatment; it probably means that physicians are being affected by the tremendous growth there has been recently in all types of personal injury litigation.

More people than ever before are receiving medical attention and more are starting lawsuits against physicians when recovery is less than complete.

Liability Insurance

For this reason, it is essential that every physician carry liability insurance to protect him against all possible claims. The physician should be aware, however, that there are some inadequate policies on the market today and an attorney should be consulted before contracting for insurance that may not cover the doctor's particular circumstance. Additional coverage insofar as limits are concerned is relatively inexpensive and should be carried in sufficient amount to cover all possibilities.

Prior to the 1967 Session of the General Assembly of Illinois, the greatest recovery that could be had for wrongful death was $30,000 but this limitation has now been removed and there is no limit in the amount which may be recovered in the case of wrongful death. This means that in malpractice cases resulting in death, the verdict could be extremely high. It is therefore recommended that all physicians take a look at their malpractice insurance policies to determine that they are properly covered and in adequate limits. The cost of this insurance does not materially increase with the increase in limits and therefore extremely high limits are suggested.

A physician today is a "sitting duck" for a lawsuit even though he may in no way be guilty of negligence. And lawsuits to defend, no matter how meritorious, require the expenditure of time and money.

Legal implications in this field are wide, but basically the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

While the right kind of insurance in sufficient amount will protect the physician financially, steps should be taken by all doctors to help minimize the filing of lawsuits of this kind and to work for reduction in the number of guilty verdicts being obtained.

The American Medical Association has prepared, and has available for distribution, several interesting pamphlets and papers on this subject. The pamphlet entitled, "Professional Liability and the Physician," reprinted from the February 1963 issue of the Journal of the American Medical Association, contains this statement:

Physician's Responsibility

"In the final analysis, the physician himself must share the responsibility for the continuing existence of the unpleasant professional liability situation. Many physicians have been satisfied to pay their professional liability insurance premiums and thereafter to sit back complacently, doing nothing until they become a target. Every physician must be brought to realize that this money payment is only part of his insurance program; a much more important part is his contribution of time, study, and attention to put into effect all possible measures to safeguard the patient, himself, and his colleagues. Professional liability is in no sense merely an insurance problem. It is a medical problem and must be combatted by members of the medical profession."

The AMA phamphlet goes on to say that "prevention is the best possible defense against claims and suits" and lists these 20 prevention "commandments":

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. The physician must avoid making any statement which constitutes, or might be construed as constituting an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of

any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The Physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience except after a reasonably complete explanation of the procedure and its risks and possible complications and after obtaining a signed consent from the patient and from the patient's spouse if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes, and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

The general counsel for the Illinois State Medical Society has given the following suggestions on how to avoid and defeat malpractice suits:

1. Physicians should conduct their practice in hospitals so that they comply with and live up to the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that frequently cases are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

Physician and Hospital Liens

Paragraph 101.1 of Chapter 82, Illinois Revised Statutes 1967, provides that every licensed physician practicing in the State of Illinois who renders service to an injured person, except services rendered under the provisions of the Workmen's Compensation Act and Workmen's Occupational Diseases Act, shall have a lien upon all claims and causes of action for the amount of his reasonable charges up to one-third of the sum recovered by the injured person. In order to effectuate this lien, notice in writing must be given to the injured person and also to the person or persons against whom such claim or right of action exists.

Under paragraph 97 of Chapter 82, Illinois Revised Statutes 1967, not-for-profit hospitals and those hospitals maintained by a county shall have a lien on all claims or causes of action for the amount of reasonable charges at ward rates up to one-third of the amount recovered. Again, in order to perfect the lien, it must be filed in the same manner as the physician's lien described above.

While the language is substantially the same under both liens, they are entirely separate enactments, neither is subservient to the other and, therefore, both the hospitals and the physicians can recover up to one-third of the amount received by the patient.

A suggested form of physician's lien notice is as follows:

NOTICE OF LIEN
In favor of John M. Jones, M.D.
1424 Chestnut Street
Springfield, Illinois

Dated this ..... day
of ....., 19.....
TO: .....
.....
.....

I am advised that ....., whose address is, ..., has a claim, right, or cause of action against you for injuries received, resulting from an accident on or about .....

You are notified that I claim a lien upon such claim, right, or cause of action for reasonable charges for medical services rendered said ..... on account of said injuries, the total amount of such lien not to exceed one-third (⅓) of any sums due or paid to such injured person by compromise, settlement, or satisfaction after the satisfaction of any attorney's lien, if any.

This lien is claimed pursuant to an Act providing for a lien for physicians rendering treatment to injured persons approved July 23, 1959 (Chap. 82, Sec. 101.1 through 101.6, Ill. Rev. Stats., 1967).

Money paid in settlement of this claim or in settlement or payment of any judgment or decree on this claim is subject to this lien, and before making settlement, you should consult with me and see that this lien is satisfied.

.....
Signature

(This notice to be served on both the injured person and the parties against whom such claim or right of action exists, by certified mail or in person.)

Suggested form of authorization to be used by lawyer:

(Place) (Date)

"I, ..., hereby authorize and direct ....., my attorney, or attorneys to pay from the proceeds of any recovery in my case to Dr. ....the reasonable amount for professional services in the treatment of injuries sustained by me and/or my wife and /or child or children, as the case may be, in an accident which occurred on ....., 19....., said payment to include professional services heretofore rendered and those rendered to the time of the settlement or other disposition of my case for the treatment of said injuries, and fees for testifying in court."

"I further authorize said Doctor to furnish said Attorney with any reports he may request in reference to my injury. I understand that this in no way relieves me of my personal responsibility to pay all such medical charges."

Witness .....
Signed .....

Admissibility in Evidence of Deliberations of Tissue Committees

In 1961 the Illinois legislature passed an act in which one of the purposes was to prevent the admissibility in evidence and making public the deliberations and findings of tissue committees. The act is set out at paragraphs 101-105 of Chapter 51, Illinois Revised Statutes 1967, and is as follows:

"101. All information, interviews, reports, statements, memoranda or other data of the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or in-hospital staff committees or accredited hospitals, but not the original medical records pertaining to the patient, used in the course of medical study of the purpose of reducing morbidity or mortality shall be strictly confidential and shall be used only for medical research.

102. Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency or person.

103. The furnishings of such information in the course of a research project to the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or to in-hospital staff committees or their authorized representatives, shall not subject any person, hospital, sanitarium, nursing or rest home or any such agency to any action for damages or other relief.

104. No patient, patient's relatives, or patient's friends named in any medical study, shall be interviewed for the purpose of such study, unless consent of the attending physician and surgeon is first obtained.

105. The disclosure of any information, records, reports, statements, notes, memoranda or other data obtained in any such medical study except that necessary for the purpose of the specific study is unlawful, and any person convicted of violating any of the provisions of this Act is guilty of a misdemeanor."

While there have been no decisions under the act quoted by any of the Illinois appellate courts or the Supreme Court, it would appear that a tissue committee would come within the meaning of "inhospital staff committees of accredited hospitals," and, therefore, would be inadmissible in evidence and considered private and confidential. Unfortunately, the act does not define accredited hospitals, but this would probably mean either licensed hospitals or those accredited by the medical professions. (There are only 10 licensed hospitals in Illinois which have not been accredited by the medical professions.)

In addition to the above statute, the fact that tissue committees are not required by Illinois law, but are established through the voluntary co-operation of the hospitals and the medical profession for the betterment of medicine through research of prior cases, would be a powerful argument against admissibility.

Another legal argument against the introduc-

tion in evidence of such records would be the fact that the results would be the deliberations of a committee and there would be no way to cross-examine a committee, which would mean that a fundamental right was being lost by one or more of the litigants in the case.

As stated above, there are no decisions in Illinois which can be relied upon, but it is the opinion of the ISMS general counsel that such records cannot legally be used in any legal action.

It should be pointed out that in most instances subpoenas and subpoenas duces tecum (produce the records) are issued by the clerk of the court on application of one of the parties litigant and no determination is made as to the admissibility of the testimony or records until the witnesses and records are produced in court. It is suggested that if a subponea or court order is ever received involving the records and deliberations of the tissue committee, your attorney be contacted immediately in order to file appropriate motions to suppress the production of the records. If the trial ccurt should hold that such records are admissible, it is then suggested that an appeal be made to the Supreme Court of Illinois on this question, for if such records are produced, it could conceivably have the result of diminishing the efficiency or the ultimate abandonment of such committees, with the result that research and advancement in the art of medicine would be retarded.

Consent by Minors to Medical Treatment and Operations

The general law in Illinois is that a minor cannot give legal consent or waive any rights which he has under the law. In the year 1961, the Illinois legislature made an exception to this rule by specifically providing that consent to the performance of medical or surgical treatment by a licensed physician could be executed by a married person who is a minor or a pregnant woman who is a minor and shall not be voidable because of such minority. This act further provides that any parent who is a minor may consent to the performance upon his or her child of medical or surgical procedures by a licensed physician and that the consent shall not be voidable because of such minority.

The act referred to above is set out at paragraphs 18.1 and 18.2 of Chapter 91, Illinois Revised Statutes 1967.

Employment Contract Between Physician and Patient

The relationship between a physician and a patient is one of contractual relationship and, therefore, a physician is under no legal requirement to accept anyone as a patient unless he so desires. This rule is true in the case of an emergency even though no other physician is available.

Legally, a physician has the right to refuse treatment in the case of an accident or other emergency and could not in any way be held liable for refusing to administer aid. (*This is strictly the legal answer and does not involve the moral or ethical question.*) The rendering of such services as may be necessary in the case of an emergency does not of itself give rise to the relationship of physician and patient and the physician is under no obligation to continue treatment beyond the emergency.

The physician in rendering emergency treatment, however, must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

Continuation of Treatment

A physician or surgeon, on undertaking an operation or treatment, is under the duty, in the absence of an agreement limiting the service, of continuing his attendance, after the operation or first treatments, as long as the case requires attention; and a surgeon, in his treatment subsequent to an operation, is required to exercise reasonable and ordinary skill and care.

The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship of physician and patient, by mutual consent of the parties, by the discharge of the physician by the patient, or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attendance.

A physician has the legal right to withdraw from a case if the patient breaks the contract by failure to follow the medical advice or treatment and direction of the physician, but the relationship cannot be terminated until the physician has advised the patient of his withdrawal from the case and has allowed the patient a reasonable length of time to procure another doctor.

Written Notice

What is reasonable notice to the patient depends upon the circumstances of each case. Factors which must be taken into consideration are the condition of the patient, the size of the community, and the availability of other physicians. In order to be completely safe, prior to withdrawal from the case, the physician should advise the patient in writing of his intent to withdraw, his reasons therefor, and the fact that he will make available the patient's case history and information regarding diagnosis and treatment to the new physician when selected by the patient. Should the patient return to the original physician stating that he has been unable to procure other medical aid, treatment should not be refused until a replacement has been obtained.

A physician has the right to leave his practice temporarily if he makes provisions for the attendance of a competent physician during his absence. This notice, which again preferably should be in writing, should be in sufficient time so that patients can obtain replacements of their own choice if they do not desire to consult the physician temporarily handling the practice of the absent physician.

GOOD SAMARITAN BILL

The 1965 Legislature passed and the Governor signed Senate Bill 395, the so-called "Good Samaritan Bill." This bill provides that any physician who, in good faith, provides emergency care without a fee at the scene of a motor vehicle accident or in case of nuclear attack shall not as a result of his acts or omissions, except in the case of gross willful or wanton negligence, be liable for damages. Paragraph 2a of Chapter 91, Illinois Revised Statutes, 1967.

The physician in rendering emergency treatment other than that necessitated by motor vehicle accidents or nuclear explosions must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

CONSUMER FRAUD ACT

This act is designed to protect the consumer. In part it reads,—"The act, use or employment by any person of any deception, fraud, false pretense, false promise, misrepresentation, or the concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise, whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice." The term merchandise includes any objects, wares, goods, commodities, intangibles, real estate, or services.

COMMITMENT OF PATIENTS TO MENTAL HOSPITALS

The State of Illinois adopted in 1963 a Mental Health Act which went into effect July 1, 1964, which Act is set out under Chapter 91½, Illinois Revised Statutes, 1967.

Under the provisions of this Act and the Youth Commission Act, there are seven ways in which an individual may be admitted to a mental hospital.

1. Informal admission
2. Voluntary application for admission
3. Admission on certificate of one physician
4. Admission on certificate of two physicians
5. Hospitalization upon court order
6. Emergency admission, except for mentally retarded persons
7. Special procedures by the Youth Commission

Informal admission:

Any person, as to admission for mental illness to a state hospital, may be admitted without formal application if the superintendent, after examination, deems the person suitable. Such patient is to be released on his request at any time between the hours of 9 a.m. and 5 p.m. and he is to be advised of such right when he is admitted. This section does not apply to the person who is a patient of a physician and is admitted to a licensed private hospital or the psychiatric unit of a general hospital under the supervision of such physician.

Voluntary application for admission:

Any person who is mentally retarded or in need of mental treatment or is alleged to be in need of mental treatment or being mentally retarded may be admitted to a hospital if, in the judgment of the superintendent, such person is a proper subject for voluntary admission after application has been filed, with the application being presented by the person himself or his attorney or relative with his consent or if a minor, by his parent or guardian. Upon this type of admission, the patient has the right to leave the hospital 15 days after having given notice in writing of his desire to leave and upon admission the patient shall be advised both orally and in writing of this right of release. The advice so given is given to the patient and his relatives, parents, guardian or attorney if any such accompany the patient to the hospital. However, this release in 15 days may not take place in such period if a petition for hospitalization upon court order is filed within such 15 days period.

The patient also may be discharged by act of the superintendent.

While the voluntary patient and those admitted on certificate of one physician or upon certificate of two physicians may be restrained and given such standard treatment as fits the patient's welfare, no surgery may be performed except by consent of the patient or the parent or guardian.

Admission on certificate of one physician:

The superintendent of a mental hospital may receive and detain as a patient any person alleged to be in need of mental treatment who does not object thereto upon the application signed by a proper relative of the patient or peace or health officer or an officer of any proper charitable or proper welfare institution or by the superintendent of a hospital operated by the state or a political subdivision thereof, or by a friend of the patient together with the certificate of one examining physician executed within 10 days prior to such admission. Prior to admission the superintendent of the mental hospital shall cause the patient to be again examined in order to confirm the need for hospitalization. If the hospital determines within 15 days after admission that the patient should be detained for further care and treatment and the patient does not agree to re-

main in the hospital as a voluntary patient, the certificate of another examining physician supporting the application is required.

Admission on certificate of two physicians:

The same general procedure is followed here as in the case of one physician, except that the consent of the patient is not required, but within five days after his admission he shall consult at the hospital with a magistrate or other judicial officer, at which time he shall be advised of his right to hearing, at which hearing he must be represented by counsel and may present evidence. After admission the patient is forthwith to be examined by some other physician than said two physicians and must be found to be in need of treatment. The patient also has a right to further hearing any time prior to expiration of 60 days from his admission. If this is not asked, the superintendent must arrange in said period to have a hearing. Other provisions also provide for further periodical review of need for hospitalization.

Hospitalization upon court order:

Whenever any person shall be, or supposed to be, mentally retarded or in need of mental treatment, any reputable citizen of this state may file in the Circuit Court the verified petition alleging that the individual is in need of mental treatment and that he be admitted to, and confined to, a hospital for the mentally ill. Upon the filing of the petition the court shall have power to make necessary temporary orders of restraint and a hearing shall be had after an examination has been made by a physician or psychologist appointed by the court. At the hearing the patient may be represented by counsel and has the right to a trial by a jury of six. When the patient demands a jury, one of the six members shall be a physician or a psychiatrist dependent upon question of mental treatment or mental retardation.

Emergency admission, detention:

Whenever a petition is filed in the Circuit Court by a reputable citizen alleging that the condition of an individual is such that immediate restraint is necessary, which petition is accompanied by a certificate of a physician, the individual may be confined in a mental hospital for a period not exceeding 15 days.

This new Mental Health Act not only appears to contain adequate provisions for the confinement of mental cases, but also provides sufficient safeguards so that an individual cannot be wrongfully restrained for an undue period of time. In fact, it would seem remote that abuses would happen under the numerous safeguards provided. As an example, any advice as to the rights of the patient must be given in a language with which the patient is familiar.

The State's Attorney of each county is charged with the responsibility of the enforcement and operation of this Act and this is the office which should be contacted by the physician when dealing with mental patients. The clerks of the courts concerned have been furnished forms to be employed under the Act and it is provided that all forms shall comply substantially with those so furnished so that it is obvious that one should employ the same.

INTERNAL REVENUE CODE

It should be evident to the busy physician that it is just as unwise for him to be his own tax consultant as it is for every man to be his own doctor. The physician is well aware that in seeking to keep abreast of all of the ramifications and developments of modern medicine, he has a burden that is becoming increasingly difficult to sustain and that he has very little time to devote to subjects as complex as taxation, which is rightfully the province of his accountant and lawyer.

Taxation in the United States is complex and many tax matters have no particular application to the medical profession as such. However, the doctor as a citizen should be aware that he is greatly affected by a subject so varied and so complicated that the statutes themselves require some 1,500 pages to be set forth. And he should know that sections 1(a) through 8023(b) are printed in a size of type that should be of some benefit in fees to practitioners who concern themselves with the human eye. Surely the point that physicians are well advised to place their problems with accounting and legal advisors is further exemplified by such facts as the following:

Regulations implementing the Internal Revenue Act require some 9,700 pages for them to be spelled out and that, in order to designate the different regulations, the government needs to entitle the regulations as Regulation Section 1.0-1 through Regulation Section 301.770-11.

Just as the patient would be so much better served if he saw his doctor regularly before difficulties become advanced, so the physician's interests would be better served if he would seek advice on income and estate tax problems before the fact, rather than after problems have arisen.

PROCEDURES AND REPORTS IN CONTROL OF NARCOTIC DRUGS

Physicians are subject to control by both the state of Illinois and the federal government in relation to narcotic drugs. The numerous provisions of the federal regulations are set forth in a fairly lengthy pamphlet entitled, "Regulations No. 5 Relating to the Importation, Manufacture, Production, Sale, etc., of Opium, Coca Leaves, Isonipecaine or Opiates," which was reprinted April 1, 1957, and is available at a cost of 45 cents through the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. This is published by the Bureau of Narcotics of the U. S. Treasury Department.

The state of Illinois' "Uniform Narcotic Drug Act" has been in effect since Jan. 1, 1958. It is found in paragraphs 22-1 through 22-49, inclusive, Chapter 38 of Illinois Revised Statutes, 1967. The Division of Narcotic Control's current rules and regulations to implement the Act have been in effect since Apr. 1, 1960. They cover such matters as prescriptions and official forms therefor, emergencies excusing use of other than official prescription forms, reporting of loss or theft of such prescription blanks, records to be kept by the physician, dispensing of hypodermic syringes and needles, prescribing procedures in hospitals, and other subjects related to narcotic drugs. The Act and the rules and regulations are available at no cost through the Division of Narcotic Control, 623 E. Adams St., Springfield.

Further, the state of Illinois has had in effect since Jan. 1, 1960, a "Uniform Drug, Device and Cosmetic Act." Its rules and regulations control such things as the keeping of adequate records, for a period of two years, of all purchases and dispositions of dangerous drugs as such drugs are defined by the Act. A publication containing the Act and the pursuant rules and regulations is also available through the Division of Narcotic Control in Springfield.

All physicians are urged to have in their possession copies of both the state and federal narcotic control acts and the rules and regulations implementing them. As these laws and regulations are changed from time to time, every effort should be made to have the current rules.

PROCEDURES AND REPORTS AS TO COMMUNICABLE DISEASES

In order to be conversant with the presently governing rules and regulations as to the control of communicable diseases and the physician's duties as to reports and procedures in relation to these afflictions, it is suggested that the physician apply to the Department of Public Health of the State of Illinois at Room 500, State Office Building, Springfield, for the publication entitled, "Rules and Regulations for the Control of Communicable Diseases," which was revised July 1, 1959.

HOW TO WILL YOUR BODY OR ANY PORTION THEREOF TO SCIENCE

The law in the State of Illinois as to the right of an individual to leave his body or particular parts thereof to science by will or agreement is not at all clear. While there are instances of medical science receiving dead bodies or parts thereof under provisions in wills and agreements made prior to death, such disposition has never been passed upon by the Illinois courts of last resort. There is no statutory authority in Illinois specifically providing for such disposition.

Illinois does have an Act covering deceased bodies which are to be buried at public expense. These bodies may, under certain conditions, be used for advancement of medical science. The Act is set forth in paragraph 19, Chapter 91, Illinois Revised Statutes 1967, and is as follows:

"Superintendents of penitentiaries, houses of correction and bridewells, hospitals, state charitable institutions and county homes, coroners, sheriffs, jailors, funeral directors and all other state, county, town and city officers, in whose custody the body of any deceased person required to be buried at public expense, shall, in the absence of disposition of such body, or any part thereof by will or other written instrument, give permission to any physician or surgeon licensed in Illinois, or to any medical college or school, or other institution of higher science, education or school of mortuary science, public or private, of any city, town or county, upon his or their receipt in writing of request therefor, to receive and remove free of public charge or expense, after having given proper notice to relatives or guardians of the deceased, the bodies of such deceased persons about to be buried at public expense, to be by him or them used within the state, for advancement of medical, anatomical, biological or mortuary science. Preference shall be given to medical colleges or schools, public or private and such bodies to be distributed to and among the same, equitably, the number assigned to each, being in proportion to the students of each college or school: except, if any person claiming to be, and satisfying the proper authorities that he is of kindred of the deceased asks to have the body for burial, it shall, in the absence of other disposition of such body, or any part thereof by will, court order, or other written instrument, be surrendered for interment. Any medical college or school, or other institution of higher science education or school of mortuary science, public and private, or any officers of the same, that receive the bodies of deceased persons for the purposes of scientific study, under the provisions of this Act, shall furnish the same to students of medicine, surgery, and biological or mortuary sciences, who are under their instruction, at a price not exceeding the sum of $5.00 for each and every such deceased body so furnished."

It should be noted that in the above law it is provided that disposition shall be made only in case the deceased has not specifically made disposition by his will or other written instrument. This would tend to support an argument that the deceased does have the right to dispose of his body as he sees fit, but to make it completely clear a new act specifically giving this power should, if possible, be adopted by the legislature.

The rather recent discovery that certain parts may be removed from a dead body and used in a living person has greatly increased the need for cadavers and parts thereof. Any one wishing to make a donation should so provide by his will and notify the institution to receive the body, or

any part thereof, of this provision in his will and also notify the executor of the will and his next of kin, or whoever is the most likely to be notified immediately of his death, for time is of the essence in the case of transplants.

AUTOPSY

In Illinois, the heirs and next of kin can bring an action for mutilation of the body in those cases where an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed, in Illinois, when ordered by the coroner or upon written consent given by the next of kin. The coroner may order an autopsy directly against the wishes of the next of kin.

THE MEDICAL WITNESS

It is difficult to find a field of law in which expert evidence is of greater importance than the testimony of the physician in accident cases. The carnage and mutilation on highways alone result in many thousands of lawsuits a year and the busy physician finds that attending court is a burden that often cannot be avoided.

There may be hope that the growing use of depositions will reduce some of the load from both physicians and attorneys as disclosure of evidence through deposition is likely to result in settlement before a case is brought to trial. Nevertheless, all signs indicate that the average practitioner can expect an increase in the number of times he will be called upon as an expert witness in the coming years.

It is suggested that, if the physician wishes to better prepare himself as to medical jurisprudence, there are a number of sources which can give him an insight into what he may expect in the forum and give him greater confidence as to this aspect of his practice. Such sources, without even the suggestion that the following begin to exhaust a listing are:

1. Doctor and Patient and the Law, by Attorney C. Joseph Stetler and Alan R. Moritz, M.D., Director of the Institute of Pathology at Western Reserve University, Fourth Edition, published in 1962 by The C. V. Mosby Company of St. Louis.

2. Chapter III on Evidence in Law in Medical and Dental Practice by Lott and Gray, published in 1942 by The Foundation Press of Chicago.

3. Medical Trial Technique by Attorney Irving Goldstein and Willard Shabat, M.D., published in 1942 by Callaghan and Company of Chicago.

4. Lawyers Medical Cyclopedia of Personal Injuries and Allied Specialties, which consists of seven volumes and is an elaborate treatment of the subject; published in 1962 by The Allen Smith Company of Indianapolis.

5. The Rights and Rewards of the Medical Witness by Nordstrom, published in 1962 by Thomas Publishing Company of Springfield.

MEDICAL CORPORATIONS

In 1963 the Illinois Legislature for the first time authorized the formation of medical corporations (Paragraph 631 through 647 Chapter 32 Illinois Revised Statutes, 1967). Under this act one or more physicians licensed to practice medicine may organize as an Illinois business corporation. All officers, directors and shareholders of the corporation must be licensed under the Medical Practice Act.

The formation of such a corporation has the advantage of giving the physicians in such a corporation limited liability and has the possibility of some tax advantages.

INTERPROFESSIONAL CODE FOR PHYSICIANS AND LAWYERS OF ILLINOIS

The following Interprofessional Code for Physicians and Lawyers of Illinois was drafted by a Special Committee on Medical-Legal Cooperation of the Illinois State Bar Association and the Liaison Committee of the Illinois State Medical Society to serve as a guide to physicians and lawyers. It has been approved by the governing board of both the Illinois State Bar Association and the Illinois State Medical Society.

Preamble

The purposes of this Code are to establish standards of practice and of ethical conduct for physicians and lawyers in those areas in civil cases where there is and will continue to be an interrelationship of medicine and law, and thereby to improve the practical working relationships of the two professions, to protect the legitimate interests and the rights of the patient-client, of the physician, the lawyer, and of society, and thereby to help advance the more effective administration of justice.

The provisions of the Code constitute recognition that the members of each profession have an obligation not only to the individual who obtains their advice and assistance but also to the community and society as a whole, and to all other members of their own professions. The objectives of the Code can be achieved only if the members of both professions acquaint themselves with these standards of practice and follow them, subject to rules of law and principles of medical and legal ethics.

ARTICLE I
Attending Physician's Medical Reports and Conferences

Purpose of Physician's Report

1. Information relative to an attending physician's treatment of a patient whose physical or mental condition is an issue in litigation is of prime importance to the parties involved in litigation. To properly prepare his client's case for trial

and to be in a position to properly represent his client in settlement negotiations, the patient's lawyer has the duty of acquiring pertinent information from the attending physician. During the course of litigation, it becames necessary for the lawyer to correspond with and confer with his client's physician and to obtain written reports from the physician.

Keep Complete Records

2. The attending physician should prepare, keep and preserve full and complete records of his examination, diagnostic findings (laboratory), and treatment of the patient.

Request for Report

3. When a medical report is desired by the lawyer, he should make a written request for it from the attending physician, and this request should be accompanied by a written authorization from the client for the release of the information sought from the client's physician. The request should ask the physician to give the following specific information:

(a) History of the occurrence leading to the injury or condition, as given by the patient to the physician.
(b) Pertinent subjective complaints elicited from the patient.
(c) Pertinent objective findings made by the physician throughout the course of treatment.
(d) The physician's diagnosis.
(e) Interpretation of x-rays, electroencephalograms, electromyograms, and any and all other pertinent data used in the treatment and diagnosis (source and interpretation should be stated).
(f) Treatment rendered by the physician to the patient.
(g) The physician's opinion as to whether there is permanent residual from the injury or condition and the extent thereof.
(h) The prognosis.
(i) The physician's opinion as to the necessity of further medical or surgical treatment.

The request for a report should be accompanied by a statement that the lawyer will endeavor to provide for the payment of the physician's fees out of any settlement or satisfaction of judgment.

The Physician's Report

4. The physician has the obligation to cooperate with his patient's lawyer and should as soon as practicable after receiving the request for it supply the patient's lawyer with a written report. This report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request for a report. In preparing the report, the physician should examine his own records and where practicable, the records of any hospital he deems necessary pertaining to the treatment of the patient.

The attending physician should not give written or oral reports concerning his patient to attorneys, adjusters, or investigators representing parties whose interests are adverse to those of the patient without express written authorization from the patient.

Report Should Be Complete

5. The report to the lawyer should be objective, impartial and complete. The attending physician should not give, and should not be asked to give a report that does not comply with these standards.

Conference Between Physician and Lawyer

6. Prior to the submission of a medical report by the attending physician to the patient's lawyer, conferences may be required between the patient's physician and lawyer. Conferences at the request of either the physician or the lawyer should be arranged at the mutual convenience of each. At the conference there should be candid discussion of the medical aspects of the litigation to promote complete understanding between the patient's physician and lawyer.

ARTICLE II

Examining Physician's Medical Reports

The "examining physician," as the term is used in the Code, differs from the "attending physician" and the "expert" in that he does not prescribe treatment and is not necessarily expected to testify at the trial. His examination is made at the request of the lawyer for one or both of the parties or at the request of the court. Should he later testify at the trial he testifies as an expert.

Request for Examination and Report

1. Where the examination is made at the behest of either party, a written request for examination should be sent to the physician by the lawyer asking for the examination stating the nature of the examination desired.

The request should be specific and request the physician to give the following information:

(a) Pertinent subjective complaints elicited from the patient.
(b) Pertinent objective findings made by the physician.
(c) The physician's diagnosis as of the time of the examination.
(d) Interpretation of x-rays, electroencephalograms, electhomyograms and any and all other pertinent data used in the diagnosis (source of interpretation should be stated).
(e) The physician's opinion as to whether there is a permanent residual from the injury, and the extent thereof.
(f) The prognosis.
(g) The physician's opinion as to the necessity of further medical or surgical treatment.

Report of Examination

2. The examining physician should send the report of the examination to the lawyer requesting the examination as soon as practicable after the

examination. The report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request.

Report is Confidential

3. The examining physician shall not give medical information to the opposing lawyer without the authorization of the lawyer who requested the examination, unless the examination is pursuant to order of court.

Keep Complete Records

4. The examining physician should prepare, keep and preserve full and complete records of his examination and diagnostic findings (laboratory).

Report Should Be Complete

5. The report to the lawyer should be objective, impartial, and complete. The examining physician should not give, and should not be asked to give a report that does not comply with these standards.

Examination at the Request of the Court

6. Provisions for examination at the request of the court, and the procedure to be followed, are covered by rule of court or by statute.

Copy of Report to Employee in Workmen's Compensation Cases

7. In Workmen's Compensation cases, the examining physician selected by the employer is required to deliver a copy of his report to the injured employee or his lawyer, unless the employee has a physician of his own selection present during the examination.

ARTICLE III
Medical Fees

Attending Physician

(1) The attending physician of a patient whose physical or mental condition is the subject matter in litigation may, in the manner provided by the Statutes of the State of Illinois, perfect his lien for medical fees for his services rendered to the patient.

(2) The physician should also notify the lawyer for the patient of his lien by sending him a copy of the Notice of Lien.

(3) The lawyer for the patient should explain to his client the nature of the lien and necessity for satisfying it out of any recovery. The lawyer should take all reasonable steps to assure payment for the physician's services out of any recovery made for the client. If the lawyer finds that he cannot accomplish this, he should notify the physician immediately so that he may take steps to enforce his lien.

(4) In the event that the attending physician expends time in preparing a report, in appearing at a deposition or in court, or in any other manner for his patient, the physician shall be entitled to a reasonable fee from his patient. The lawyer shall take all reasonable steps to see that his client pays the said fee.

(5) The attending physician shall not charge his patient a higher fee because the patient may recover the amount of these charges as the result of a claim or litigation.

(6) The lawyer should not pay the attending physician's fee except with the client's funds.

(7) The physician's fee shall not be contingent upon the outcome of the litigation.

Examining Physician

(1) A physician who makes an examination at the request of a lawyer shall charge the reasonable value of his services so rendered on the same basis as if his services were not rendered to patient in connection with litigation. The physician's charge for reports, conferences with the lawyer, and appearances at depositions and in court shall also be based upon the reasonable value of those services.

(2) The said charges shall be the obligation of the client and not of his lawyer. The lawyer shall make every reasonable effort to see to it that his client pays the fee of the examining physician for all services rendered by the physician to or in behalf of said patient.

(3) The examining physician's fee shall not be contingent upon the outcome of the litigation.

Experts

(1) The physician whose services may be rendered as an expert in connection with any phase of litigation, shall not charge more than the reasonable value of his services. The fee shall be the obligation of the patient-client and not of his lawyer.

(2) The lawyer shall make every reasonable effort to see that his client pays the fee of the expert.

(3) The expert's fee shall not be contingent upon the outcome of the litigation.

ARTICLE IV
The Physician At The Trial Or Hearing On Deposition

Conferences Prior to Trial

(1) The lawyer and the physician should arrange to confer with each other before the physician testifies at any hearing, and if possible, before the trial commences. At the conference the common problems involved in the case should be discussed. The lawyer has the responsibility of acquainting the physician with any particular legal problems which might involve the physician, and with the assistance of the physician should determine the areas in which the physician will be called to testify. The lawyer should familiarize the physician with the contents of any proposed hypothetical questions.

(2) The physician should make every effort to cooperate with the lawyer in regard to this conference. Each should be mindful of the demands on the other's time in making appointments for conferences, in the time spent on conferences, and

in notifying the other promptly if, for any reason, either is unable to attend the appointed conference. While the physician should recognize that he is not an advocate and the lawyer is, he should at the conference familiarize the lawyer with the medical problems involved, the areas in which he (the physician) feels qualified to testify, and the facts and opinions about which he is prepared to testify.

Court Arrangements

(1) The lawyer should make every effort to be economical in his use of the physician's time. He should give the physician reasonable advance notice of when and how long he shall be needed in court, advise the physician promptly of any changes in the time of his needed appearance and should call the physician as a witness upon his arrival at court, with as little delay as possible.

(2) The physician has an obligation to be in court at the time requested. He should recognize that only a true emergency will excuse his nonattendance. In the event that such an emergency does arise, he should, as soon as possible, notify the lawyer who requested his appearance in court of his inability to be in court at the appointed time and also advise as to the earliest time he will be available to testify.

Subpoenas

(1) The lawyer should determine whether or not the physician should be served with a subpoena. If the physician is to be served with a subpoena, the lawyer should advise the physician of the reason for serving him; for example, that service of a subpoena is necessary to lay the foundation for a continuance if the physician is unable to attend the trial due to an emergency or other cause. If service of a subpoena is to be had, the lawyer should advise the physician in advance, and if possible, arrange for the service of the subpoena at a time and place satisfactory to the physician.

(2) The physician should recognize that a lawyer may deem it necessary to subpoena the physician, and that the physician is obliged to answer the subpoena as any other citizen. He should cooperate with the lawyer with regard to the time and place of service.

Conduct as a Witness

(1) It is improper for a lawyer to attempt to color or otherwise influence the professional opinion of a physician.

(2) The physician's testimony should be unbiased and given in terms understandable to the jury. He should be prepared to testify in detail as to his qualifications, the medical facts in the case, and to give his frank and honest medical opinion in regard thereto. Technical or medical terms, if used, should be carefully and fully explained. The physician should remember that he is not an advocate trying a lawsuit, nor should he feel that he is taking sides on any particular medical issue or fact.

Conclusion

If the above interprofessional code for physicians and attorneys of Illinois was followed by all parties, the following results might well be attained:

1. A greatly improved understanding of each others problems by the members of both professions.
2. A considerable savings of time by all participants.
3. Better public relations for both groups.
4. Better and easier collections of fees.
5. Better and more efficient administration of justice.

A Philosophy

I would liken our current condition to that of the atomic physicists of twenty years ago. Following the creation of the atomic bomb, these men claimed that since they had made the bomb, someone else must determine its use. The political, international, and military philosophy regarding its use and by whom, was a problem to be argued and determined by the military politicians and the public at large. History shows that the physicists were unable to hide behind their particular premise. They were forced to engage in a public dialogue and through multiple conversations, partly of their making, the code of mores relating to the dropping of the bomb became of them and by them. So must you and I, as physicians, participate in the creation of solutions to current ethical and moral problems . . . . . (C. Barber Mueller, "To Practice Solely For Cure," **Rocky Mountain Med. Jl.** [Mar.] 1968; pg. 39.)

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An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
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ABBOTT

The Product

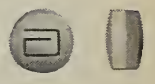
For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

New Pharmaceutical Specialties
For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.
Duplicate Single Products: Drugs marketed by more than one manufacturer.
Combination Products: Drugs consisting of two or more active ingredients.
New Dosage Forms: Of a previously introduced product.

NEW SINGLE CHEMICALS

DESFERAL Mesylate Iron Chelating Agent ℞
Manufacturer: Ciba Pharmaceutical Co.
Nonproprietary Name: Deferoxamine mesylate
Indications: Adjunctive use in acute iron intoxication.
Contraindications: Severe renal disease or anuria.
Dosage: Intramuscular or intravenous administration as described in the package insert.
Supplied: Ampuls - 500 mg. lyophilized deferoxamine mesylate.

COMBINATION PRODUCTS

DONNASEP-MP Urinary Antiseptic ℞
Manufacturer: A. H. Robins Co.
Composition:

Methenamine mandelate	500 mg.
Hyoscyamine sulfate	0.0519 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital	8.1 mg.

Indications: Urinary tract infections
Contraindications: Severe renal and hepatic dysfunction, narrow angle glaucoma, obstruction of the GI and uringary tract, cardiospasm.
Dosage: Two tablets 3 or 4 times daily.
Supplied: Capsules; bottles of 100 and 500.

FILIBON Forte Hematinic ℞
Manufacturer: Lederle Laboratories
Composition:

Vitamin A Acetate	6,000 USP Units
Vitamin D	400 USP Units
Vitamin E (Tocopheryl Acid Succinate)	30 Int. Units
Ascorbic Acid	100 mg.
Niacinamide	21 mg.
Pyridoxine HCl (B_6)	10 mg.
Pantothenic Acid	5 mg.
Thiamine Mononitrate (B_1)	3 mg.
Riboflavin (B_3)	3 mg.
Folic Acid	1 mg.
Vitamin B_{12}	5 mcg.
Ferrous Fumarate (elemental iron)	45 mg.

Indications: Anemias of pregnancy.
Contraindications: None stated.
Dosage: One tablet daily.
Supplied: Capsules; bottles of 100.

(Continued on page 559)



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017



THE DOCTOR'S LIBRARY

Surgery For Acquired Mitral Valve Disease. By F. Henry Ellis, Jr., M.D., Ph.D. 299 pages, illustrated. W. B. Saunders Co., Philadelphia, 1967, $17.

Acquired mitral valve disease is well outlined in the monograph. The text is divided into five major sections which cover most aspects of mitral valve surgery. Each section deals with a different phase of acquired mitral valve disease with minimal overlap of material.

Part one covers the history of mitral valve surgery. The bibliography in this section is complete and up-to-date. The author's purpose in presenting a lengthly bibliography was to avoid repetition in the ensuing chapters. A thorough bibliography such as this enables the reader to review specific aspects of mitral valve disease in detail if he wishes to.

The second part presents the anatomic, physiologic, and radiologic aspects of acquired valvular disease. The illustrations of diseased valves are numerous and well done. Preoperative evaluation of the patient is stressed in this section.

The third subdivision is "The Surgical Period." In this section the author presents anesthesia and surgical techniques. The various approaches to the mitral valve, utilizing open and closed techniques are outlined. This section could be a starting point for the student or resident who is interested in cardiac surgery.

The chapter on post operative care of the patient emphasize the physiologic significance of changes that occur after cardiac surgery, particulary open heart surgery. Dr. Ellis has stressed the application of basic physiology in the care of patients.

Part four deals with hemodynamic changes following surgery. The clinical results of mitral valve surgery are correlated with the type of operation in a concise manner. They are presented as over-all results from many centers and with the results obtained at the Mayo clinic.

The final section presents the author's evaluation of past and present achievements in mitral valve surgery. He also outlines future requirements.

The material set forth in this monograph is useful for the internist contemplating referring a patient for cardiac surgery. It is also a starting point for the resident participating in surgery for mitral valve disease.

Julius Conn, Jr., M.D.

Atlas: of Infant Surgery. Edited by J. Eugene Lewis. 257 pages, illus., Nov. 1967, $21.00

This useful atlas reflects the author's vast experience in the management of surgical problems of the infant. The material is presented in a concise manner and illustrations are informative and clear. A brief embryological consideration is presented in some of the topics such as congenital diaphragmatic hernia, omphalomesenteric duct anomalies and malrotation of the small intestine and colon. Clinical features, diagnosis and management are described on important subjects: respiratory distress of the neonate, intestinal obstruction and anomalies of the esophagus. The author mentions his preferences in certain techniques without neglecting others. The bibliography is updated to include recent publications. Also included is a list of textbooks to cover underemphasized areas by the author.

This basic and comprehensive atlas is a helpful guide to the pediatric and general surgeon.

Gabriel Lorenzo, M.D.

PEDIATRIC PLASTIC SURGERY—Volume I, Trauma. Francis X. Paletta. C. V. Mosby Company, St. Louis, 1967. 245 pages, 419 illustrations.

The author indicates in his preface that this volume is an atlas which has been produced to serve as a guide in the management of injured children, a problem of increasing frequency. Dr. Paletta is to be congratulated upon his accomplishment. He has presented a well organized, sound and comprehensive atlas. The book is well illustrated with photographs of good quality and line drawings, with adequate legends.

The book begins with a brief but interesting historical account of the development of plastic surgery. The following chapter is concerned with the Emergency Room. Included are specific recommendations by which patients should be treated in the Emergency Room and which require hospital care. A valuable list of equipment for emergency room surgery is presented. Basic technics in suture for lacerations of the face and scalp are illustrated. The third chapter is devoted to the prevention and treatment of thalamus and includes a case presentation. Tracheostomy and local anesthesia are dealt with in the next chapters.

The discussion of major soft tissue injuries seems particularly valuable. The text and illustrations lucidly describe the steps that are required in wound management, wound closure, and application of dressings.

Facial fractures are treated in a separate chapter and hand injuries in another. The chapter on bites includes those caused by humans, dogs, snakes, and insects. The final chapter details the management of burns and their complications. A bibliography is provided that is organized by chapter and is placed at the end of the book. References are pertinent and well selected.

The author has emphasized good sound surgical techniques and basic principles of patient management. Some of the patients who illustrate injuries do not appear to be in the usual pediatric age group, but this minor question does not detract from the good quality of the atlas. This book should be of particular interest to interns and residents who are involved in the care of injured patients.

John M. Beal, M.D.

NEURO-OPHTHALMOLOGY. Edited by J. Lawton Smith. The C. V. Mosby Co., St. Louis, 1965. 278 pages, $21.75.

This book is a transcript of the second symposium on clinical neuro-ophthalmology sponsored by the University of Miami and was held in Miami in January 1965. Like the first symposium it was directed to the clinician but unlike the first the papers presented represented the current interests of the speakers rather than an arbitrary topic which had been assigned to them. For this reason the communications are authoritative, timely and interesting. For example Smith writes on seronegative neurosyphilis, Norton writes on fluorescein angiography of the retina, Hollenhorst contributes a paper on strokes and Hedges speaks on occlusive vascular disease. It will be noted that these (and other topics not mentioned) are all of clinical interest. Basic anatomy and physiology of nerve pathways were not discussed except where they applied immediately to the subject at hand. A beautiful illustration of this is the paper by Lindenberg on neuropathology involving the lateral geniculate bodies, the optic radiation and the calcarine cortex. In all of the three sections there is a short presentation of the anatomy involved but the major portion of the discussions are devoted to case reports that illustrate the effect of vascular, degenerative or neoplastic lesions on the structures noted above. Indeed this article alone is worth the price of the entire book.

Perhaps the best recommendation that can be given is to say that this volume has the same aura of authoritative pedagogy that surrounds the editor when he lectures to an audience. All ophthalmologists with an interest in neuro-ophthalmology (and this should include *all* ophthalmologists) will benefit from reading this compilation of the current work of the authorities in the field.

David Shoch, M.D.

We flatly state that a person with a physical disability is a much better (insurance) risk than his so-called normal counterpart provided he is properly screened and placed and provided the company has an intelligent safety program.... L. A. Hyland, general manager, Hughes Aircraft Company.

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

New Pharmaceutical Specialties

(Continued from page 550)

GEVRAMET

Geriatric Elixir Vitamins and Hormones ℞
Manufacturer: Lederle Laboratories
Composition:

15 cc Pentylenetetrazol NF	100 mg.
Niacin NF	50 mg.
Ascorbic Acid (Vit. C USP)	45 mg.
Methyltestosterone NF	2 mg.
Ethinyl Estradiol USP	0.01 mg.
Alcohol USP	20% V.

Indications: Adjunct in the management of patients having mental and physical changes associated with the aging process.
Contraindications: Neurologic disorders, agitated patients, alcoholism, mammary or genital cancer, severe hepatic or cardiovascular disease.
Dosage: 15 cc. one to three times daily; females —3 weeks cyclic therapy with one week rest.
Supplied: Bottles—16 oz.

TEDRAL Expectorant Bronchial Dilator ℞
Manufacturer: Warner-Chilcott Laboratories
Composition:

Theophylline	130 mg.
Ephedrine HC1	24 mg.
Glyceryl Guaiacolate	100 mg.
Phenobarbital	8 mg.

Indications: Symptomatic relief of bronchial asthma, asthmatic bronchitis, and bronchospastic disorders.
Contraindications: Sensitivity to any of the ingredients; porphyria.
Dosage: Adults: one or two tables q.i.d.
Supplied: Tablets; bottles of 100.

NEW DOSAGE FORMS

TAO Chewable Tablets
Antibiotic-Broad Spectrum ℞
Manufacturer: J. B. Roerig & Co.
Nonproprietary Name: Troleandomycin (triacetyloleandomycin)
Indications: Primarily effective against infections due to staphylococci, streptococci, pneumococci and gonococci.
Contraindications: Pre-existing liver disease or dysfunction and in individuals who have shown hypersensitivity to the drug.
Dosage:
Adults: 250 to 500 mg. q.i.d.
Children: 125 to 250 mg. q-6-h; depending upon severity of infection.
Supplied: Tablets; bottles of 50.

A new film catalog listing U.S. Government 8mm medical films is now available. The 113 medical films in this catalog have been produced by the National Medical Audiovisual Center, Atlanta, Ga. Many rehabilitation films have been produced in cooperation with the Institute of Rehabilitation Medicine, New York University Medical Center. The National Medical Audiovisual Center plans a continuing series of 8 mm. films for the medical profession. The catalog is available through Modern Talking Picture Service, Inc., 1212 Avenue of the Americas, New York, N.Y. 10036.

Do you have patients who try to hide fear behind bravado?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you. Whether depression is open or secretive, Aventyl HCl assists you in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl® HCl
Nortriptyline Hydrochloride

800322

(See last page for prescribing information.)

OBITUARIES

*Dr. Martin Brann, Chicago, died Aug. 19 at Edgewater Hospital where he was a staff member.

*Dr. Leo E. Braunstein, Lincolnwood, died Aug. 14 at the age of 66. He was a fellow of the International College of Surgeons and a diplomate of the American Board of Abdominal Surgeons.

*Dr. Henry S. Cambridge, Wilmette, died Aug. 4 at the age of 76. He had served as chief dermatologist at Illinois Masonic Hospital and as a consultant at St. Francis Hospital.

*Dr. Burdick G. Clark, Peoria Heights, died Aug. 31 at the age of 51. He was a member of North Central Urology Association, a fellow of the American College of Surgeons, and associate professor at Northwestern University School of Medicine.

*Dr. Fay S. Comer, Cairo, died Aug. 10 at the age of 62. He was past president of Alexander County Medical Society, a member of the American College of Surgeons and American College of Physicians.

Dr. Barry N. Kelner, Chicago, died Aug. 25 at the age of 27. He was chief resident surgeon at Michael Reese Hospital.

*Dr. W. B. Kilton, a Sullivan physician for more than 50 years, died Aug. 3 at the age of 88. He had served as both president and secretary of the Moultrie County Medical Society and was a member of the ISMS Fifty-Year Club.

*Dr. Nicholas B. Pavletic, Oak Lawn, 63, died Aug. 30 at Little Company of Mary Hospital, where he had been a member of the staff.

Dr. W. J. Reuter, Bethalto, died July 20 at the age of 65.

*Dr. Elmer T. Swann, Oquawka, died Aug. 28 at the age of 76. He was currently serving as president of the Henderson County Medical Society and a member of ISMS Fifty-Year Club.

*Dr. Albert M. Wolf, Chicago, died Aug. 23 at the age of 62. He was medical director of the Michael Reese Blood bank and had been on the hospital's staff for 30 years.

*Indicates member of Illinois State Medical Society.

The Veterans Administration is guardian to approximately 650,000 incompetent veterans, incompetent dependents and minor children. Their estates amount to almost $700 million.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

MEETING MEMOS

Oct. 25—ISMS will be one of six cooperating agencies at the Professional Conference on Sex Education and Venereal Disease. The conference, sponsored by the Illinois Social Hygiene League, will take place at the Drake Hotel, Chicago, and will present the latest techniques in sex education programs and information on VD control.

Oct. 28-30 and Nov. 11-13—The Staff of the Mayo Clinic and the Faculty of the Mayo Foundation are presenting clincial reviews during both these periods. The program is acceptable for credit by the American Academy of General Practice and the College of General Practice. The registration fee is $20. Those wishing to attend should contact M. G. Brataas, Mayo Clinic, Rochester, Minn. 55901, indicating which session they would prefer to attend.

Nov. 6-7—The Cleveland Clinic Educational Foundation is presenting a postgraduate course in "Upper Gastrointestinal Disease-Clinical Aspects." For further information write to: Director of Education, The Cleveland Clinic, Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

Nov. 7-9—The American Society of Anesthesiologists is sponsoring a Conference on Respiratory Therapy. To be held at the Statler Hilton Hotel, Boston, Mass.

Nov. 7-9—The Second Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach," is being sponsored by the Mound Park Hospital Foundation along with the University of Florida's J. Hillis Miller Health Center. To be held in Redington Beach, Fla., the course is designed specifically for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees and allied personnel. The American Academy of General Practice is offering 18 credit hours for the course. For further information write to: Postgraduate Medical Education, Mound Park Hospital Foundation, 701-6th St., St. Petersburg, Fla. 33701.

Nov. 11-15—The American Public Health Association is holding its 95th Annual Meeting in Detroit, Mich., at Cobo Hall. Over 7,000 public health specialists from all parts of the world and representing more than 70 related health organizations are expected to attend. Topics of the major sessions include: citizens' participation, sex education, drug abuse and prevention approaches, prospects for dose reduction in nuclear medicine, new developments in hospital environment control and children's health problems that interfere with learning. For further information contact: American Public Health Association, 1740 Broadway, New York, N.Y. 10019.

Nov. 15-16—A Seminar on Hematology, jointly sponsored by the Illinois Medical Technologists Association, Illinois Association of Clinical Laboratories and Illinois State Society, American Medical Technologists, will be held in Chicago. Topics will include "Quality Control in Hematology," "Coagulation Procedures," "Normal and Abnormal Blood Cell Morphology." Registration fee $30.00. Additional information from Mr. Stanley Lullo, P.O. Box 13, Dwight, Illinois 60420.

Nov. 21-24—The American Heart Association will hold its 1968 Scientific Sessions at the Americana Hotel, Bal Harbour, Fla.

Nov. 22-24—The Hahnemann Medical College and Hospital of Philadelphia is sponsoring a meeting entitled, "Psychedelic Drugs."

Nov. 24-27—The Jamaica Cancer Society is sponsoring its Second Caribbean Cancer Congress at the Medical Auditorium, University College Hospital, Mona, Kingston, Jamaica. The congress will review recent advances in research and treatment of malignant disease with special emphasis on the problems relating to the Caribbean and Latin American countries. For further information write to: Kenneth A. McNeil, F.R.C.S., F.A.C.S., Secretary General, Second Caribbean Cancer Congress, 5 Tangerine Pl., Kingston 10, Jamaica. W. I.

Dec. 1—The Tenth National Conference on the Medical Aspect of Sports will be held in Miami Beach, Fla., in conjunction with the Annual Clinical Convention of the AMA. Included will be forums on the management of knee injuries, back problems and problems related to vision in sports. For further information contact: Committee on the Medical Asepcts of Sports, AMA, 535 N. Dearborn St., Chicago 60610.

Dec. 1-4—The 22nd Clinical Meeting of the American Medical Association. To be held in Miami Beach, Fla. This year's convention will feature three postgraduate courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient.

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8



TRUANT BRITISH PHYSICANS

The Voluntary Health Insurance Council of Australia[1] sent questionnaires to 730 physicians with British degrees practicing in Australia. Where possible, personal interviews were conducted. The aim of the survey, patterned after the fact-finding mission conducted by the British Ministry of Health in America, was to woo 'truant' British doctors back to England. Replies were obtained from 360 physicians—an excellent return which indicated interest in the survey.

Three main findings emerge from the survey. First, a majority of doctors who have left Britain to practice in Australia consider the Australian voluntary system superior to the British National Health Service. Second, after experience in both countries, 85% of them would not consider returning to practice under the National Health Service. But, third, nearly half the doctors, while favoring the Australian system over all, believe that health insurance benefits are in various ways inadequate.

Details of attitudes are seen in answer to questions on the British system of 'free' hospital and medical services financed from taxation: 70% of the doctors believed the system led to an unsatisfactory standard of service to patients; 80% thought the National Health Service was inefficiently run; 90% said it created an unsatisfactory relationship between the patient and doctor; and 94% said the nationalized health service led to over-use of doctors and medical facilities.

One truant physician believed that "A nationalized health service produces a generation of spoon-fed weak-kneed specimens unable to put a sticking plaster on a cut finger." Another told of a woman who had a lump on the breast and walked into the surgery eight times and left because it was overcrowded. "The system killed her." Still another remarked, "The wastage of powerful drugs is immense in the United Kingdom."

The British migrant doctors were also asked to comment on the Australian system. The majority (53%) believed that Commonwealth benefits were adequate and should be paid whether the patient contributed or did not contribute; 78% believed the free enterprise system with a choice of insurance promoted greater efficiency than other systems in providing health services. More than 85% believed in the principle of voluntary health insurance and 91% that the Australian system promoted better doctor-patient rapport than a nationalized service.

Conversely, the Australian system was thought to be inadequate for large families and for those suffering from chronic illnesses. In addition, it did not give proper coverage for major surgery or long illnesses requiring hospitalization. There was also too big a gap between benefits and normal fees charged.

T. R. Van Dellen, M.D.
Editor

Reference

1. Attitudes of British Migrant Doctors In Australia. *Medical Journal of Australia* (Mar. 9) 1968, pp. 419-420.

Smiles speak louder than words

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Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



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Clinics for Crippled Children

Twenty six clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. There will be twenty general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service, four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

November 5, Alton General—Alton Memorial Hospital
November 5, Pittsfield—Illini Community Hospital
November 6, Hinsdale—Hinsdale Sanitarium
November 7, Sterling—Community General Hospital
November 7, DuQuoin—Marshall-Browning Hospital
November 7, Peoria Cerebral Palsy (A.M.)—Zeller Zone Center
November 8, Chicago Heights Cardiac—St. James Hospital
November 12, Fairfield—Fairfield Memorial Hospital
November 12, East St. Louis—Christian Welfare Hospital
November 12, Peoria General—Children's Hospital
November 13, Champaign-Urbana—McKinley Hospital
November 13, Joliet—St. Joseph's Hospital
November 14, Macomb—McDonough District Hospital
November 14, Springfield General—St. John's Hospital
November 20, Centralia—St. Mary's Hospital
November 20, Springfield Cerebral Palsy (P.M.)—Diocesan Center
November 20, Evergreen Park—Little Company of Mary Hospital
November 21, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
November 21, Elmhurst Cardiac—Memorial Hospital of DuPage County
November 21, Decatur—Decatur & Macon County Hospital
November 22, Chicago Heights Cardiac—St. James Hospital
November 26, Danville—Lake View Hospital
November 26, East St. Louis—Christian Welfare Hospital
November 26, Peoria General—Children's Hospital
November 27, Rockford—St. Anthony's Hospital
November 27, Elgin—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

What It Takes

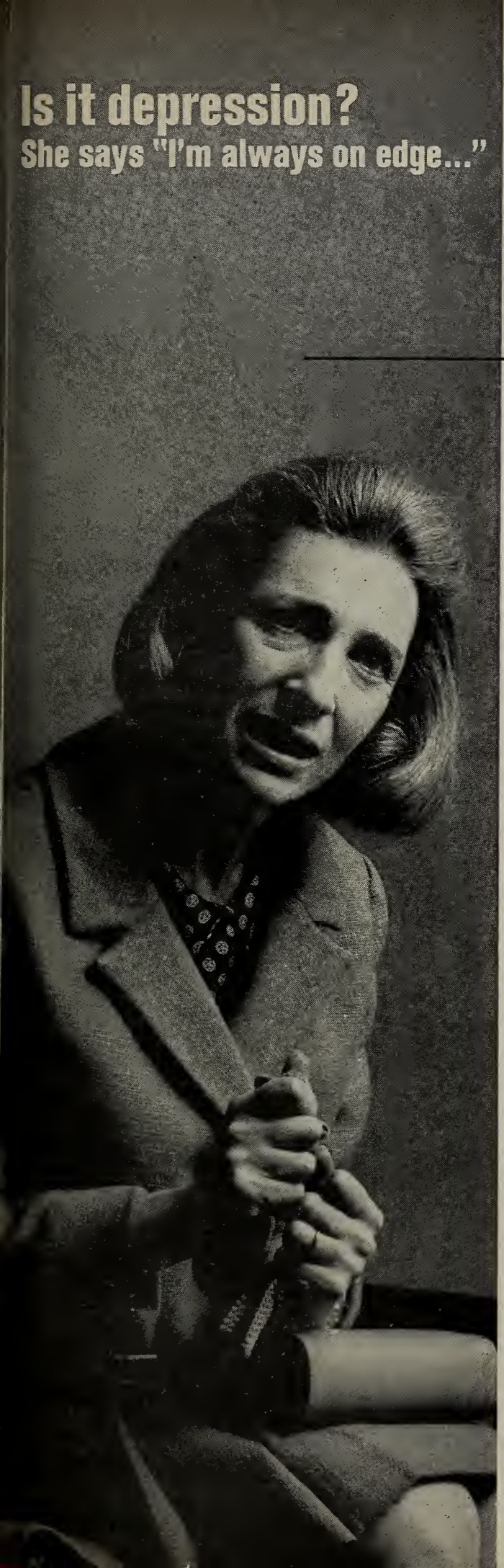
What seems to be a common sense view indicates that the fledgling M.D. should have:

1. An adequate stock of "facts" at his command to use as tools,
2. A good understanding of mechanisms of disease in order to act intelligently rather than by rote,
3. A knowledge of where to acquire new or modified data over the years with a strong motivation to do so,
4. An insatiable desire to know "why" and a constant effort to find out (This is research whether it be basic or clinical),
5. Sufficient humility and compassion to allow him to get along with contemporaries and patients.

"A Teacher Looks at Medical Education." An Editorial by Warner F. Bowers, **International Surgery** (May) 1966. **Resident Physician** (July) 1968; pg. 53.

Is it depression?

She says "I'm always on edge..."



...but her other symptoms: depressed mood, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

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Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

AMA Posture on Public Comment

The AMA Board is cognizant of the great increase in attention being given in the press and broadcast media to medicine and health care. Our profession is now the focus of one of America's greatest interests. It will constantly be in the spotlight, ending the professional reticence and privacy in which medicine functioned most of the time in the past.

Even though this interest is a tribute to the importance of medicine and the public's desire for its benefits, it brings with it the problems facing any person or organization with a key public position: much of the coverage is critical or displays a lack of understanding.

The Board of Trustees has consulted with AMA staff and public relations counsel on this increasingly important situation. The conclusions that have resulted from this intensive and thoughtful consideration are:

1. When statements about medicine are misguided or unfair, corrective statements will be issued promptly when the facts are available and an orderly response is possible.

2. We must recognize that the prominence and complexity of medicine in the United States today results in many limitations. Medicine is a constant subject of news and comment, much of which cannot be subject to a later response. Often replies cannot be carried by the broadcast medium or publication, or at best will be much less prominent than the original coverage. Quite often a responsible statement cannot be issued until the facts have ben obtained, and these may be scattered about the country or involve a local situation or require a great deal of time.

3. The frequency and complexity of these matters have increasingly diverted the officers and staff of AMA to reacting to what others do and say. This decreases the ability to work on constructive, ongoing activities that are vital to our future.

4. Staff is developing in written form the best possible anticipatory statements regarding all foreseeable circumstances. By having such matters thought out and documented when a need arises, we will be able to reduce the instances of surprise, decrease the time required for response, and assure consistency in AMA statements on these matters.

5. We will concentrate on building a positive posture by getting understanding for medicine's functions and its positions on various considerations; and by educating the press, broadcasters and opinion leaders. This will help forestall much misguided criticism and build a favorable climate that will inoculate against susceptibility to unfair criticism.

6. All state and county medical societies are urged to follow these same procedures.

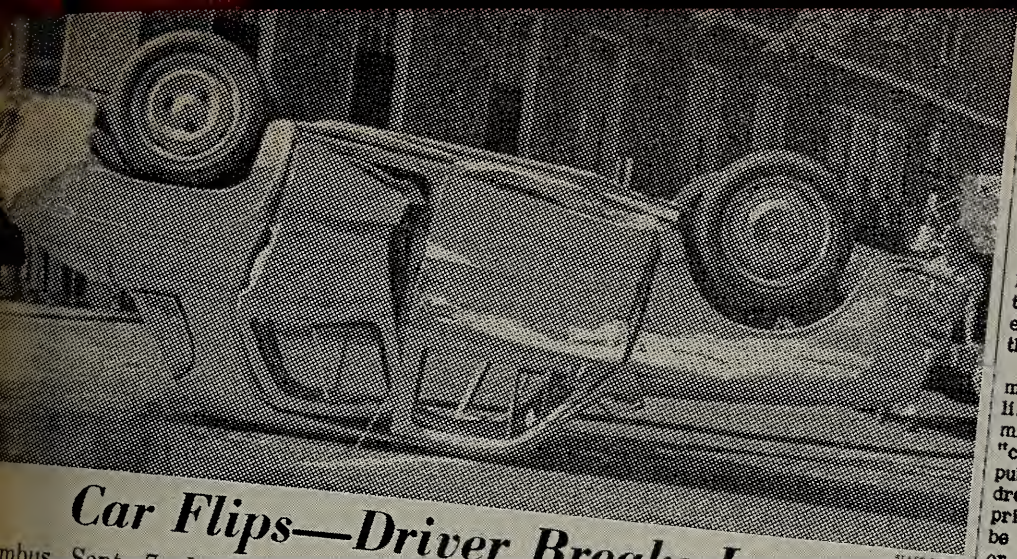
One will see many instances in which AMA responds to public comment, many in which we have acted but our effectiveness will be in correcting the source and may not be visible immediately, and instances when judgment indicates a response should not be made. In each case the best judgment and skills will have been applied to the complexities of the situation.

(Ed. Note: This statement was adopted by the AMA House of Delegates, San Francisco, June 1968.)

Cardiovascular Disease and Alcoholism

The medical histories of 922 problem drinkers were compared with those of an equal number of matched controls to measure differences in prevalence of various forms of cardiovascular disease. The drinkers were divided into three categories: (1) known, uncontrolled alcoholics; (2) suspected cases; and (3) recovered cases.

The prevalence of hypertension was 2.3 times greater among the drinkers than the controls. Differences in blood pressure between the drinkers and controls were greater for the systolic than the diastolic. Hypertension was less prevalent among the recovered cases than in the known and suspected groups, suggesting that hypertension is reversible to some extent when drinking is stopped. (Cardiovascular Disease Among Problem Drinkers. C. A. D'Alonzo and Sidney Pell. **Jl. of Occupational Med.** [July] 1968; **10**:7; pgs. 344-350.)



STAFF PHOTO

Car Flips—Driver Breaks Leg

mbus, Sept. 7. John P. Jones of
s Lane incurred a broken leg today
he was driving failed
Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top
Hasn't he had enough excitement

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

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Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

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National Intern and Resident Matching Program Formed

At a recent special meeting of the National Intern Matching Program (NIMP), the program was reincorporated as the National Intern and Resident Matching Program (NIRMP).

The original National Intern Matching Program (NIMP) was established in 1951 for the purpose of organizing and conducting a national clearing service to match the preference of medical students for internships with those of hospitals for interns.

Although the program was designed primarily for students graduating from medical schools in the United States, graduates of foreign schools, who have been certified by the Educational Council for Foreign Medical Graduates (ECFMG), may participate in the matching program. Canadians may participate without certification.

All hospitals having internship programs that are approved by the Council on Medical Education and Hospitals of the American Medical Association are eligible to participate in the program.

In initiating their participation in NIMP, both students and hospitals sign and file with NIMP an agreement to comply with the terms of the program. Neither may negotiate with nonparticipants until the matching is complete and the results are announced. Both students and representatives of the hospitals are free to conduct whatever investigations or discussions may be necessary to formulate judgments for ranking purposes. However, neither students nor hospitals may make a final commitment without going through the prescribed matching process.

AMA Lists Approved Programs

In September of the year prior to the internship appointments, the American Medical Association publishes a directory that lists and describes all approved internships and residencies offered by all U.S. hospitals. One section of this directory contains all of the information necessary for students to participate in NIMP. Then in October, NIMP sends each participating hospital a directory containing the name and medical school of each participating student.

From October until January of the following year, the students make application for internships to the hospitals of their choice, filing copies of their applications with their dean's office. During this time, the dean submits the student's credentials and recommendations to the hospitals where the student has applied for internship. The hospitals then have this information should the student make an appointment for an interview. The Christmas holiday is the time when most of these interviews take place.

By late January, both students and hospitals must have filed their confidential rank order lists at the NIMP office. Students list all hospitals to which they have made application in order of their preference and indicate those hospitals at which they do not wish to intern. Hospitals list, in order of their preference, all students applying for their internship vacancies.

Matching Begins in February

After NIMP confirms this information to both students and hospitals, the matching begins in mid-February; and the results of the matching are mailed to the students and the hospitals in mid-March.

Following the announcement of the matching results, hospitals with vacancies and students who have been unmatched are free to negotiate for appointments. Each year about 60 per cent of the available internships are filled through the matching program.

A record 8,000 medical graduates participated in the sixteenth annual National Intern Matching Program in 1967. The proportion of interns matched to federal service hospitals and hospitals with minor teaching affiliations has remained relatively constant over the past eight years. Hospitals with major affiliations have drawn increasingly larger proportions of NIMP participants.

The success of each matching depends upon the distribution of carefully prepared materials to medical students, medical schools, and hospitals; upon the cooperation of all of those involved in meeting NIMP deadlines; and upon meticulous execution of the matching process at the NIMP office.

(Continued on page 580)

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ILLUSTRATION OF PREMIUMS AND POLICY VALUES PER $1,000 OF INSURANCE

Age at Issue	Annual Premium	20th Year Policy Values	
		Accumulated Cash Value	Accumulated Dividends*
24	$12.90	$261.59	$ 63.53
25	13.30	269.31	65.79
26	13.75	277.16	68.98
27	14.20	285.14	72.27
28	14.65	293.24	75.78
36	19.45	361.30	107.90
37	20.20	370.12	112.51
38	21.00	378.99	117.07
39	21.80	387.92	121.77
40	22.65	396.90	126.55
41	23.60	405.91	131.45
42	24.55	424.02	141.43
54	40.95	516.77	222.19
55	42.90	524.54	230.31
56	44.95	532.38	238.53
57	47.10	540.25	246.76

*Dividend illustrations included above are based on present scale and are neither guarantees nor estimates for future years.

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Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

GRUNDY COUNTY: Morris, population 9,000 and trade area 25,000. Urgent need for physicians to join Clinic Corporation group of 3 G.P.'s New 119 bed hospital, clinic one block away. Clinic is well equipped and staffed with ten examining rooms, minor surgery, nurses station, administrative areas, large waiting room and ample parking. Growing commercial and industrial community. Good schools ten Protestant and Catholic Churches, various recreational facilities. Country Club and also active civic and social groups. One hour from Chicago. Salary with opportunity of increasing salary-ownership after one year. Contact: Barry S. Seng, M.D., Tratt Clinic, S.C., Morris, 312-942-3000

HANCOCK COUNTY: Carthage; population: 3,500. Four physicians, ages 54, 37, 61 and 45. Memorial Hospital 50 miles from Quincy; population 47,000. Two prescription drug stores. Office space available in hospital extended care complex if desired. Agriculture and industry area. Ten Catholic and Protestant churches. Three grade and one high school. Robert Morris Junior College located here. Nearby country club, municipal swimming pool. For further details contact: Marion Smith Geissler, Administrator, Carthage Memorial Hospital, Carthage. Phone: 217-357-3408.

HANCOCK COUNTY: Nauvoo; population: 1,100. Trade area, 4,000. Nearest doctor at Hamilton 12 miles. Nearest hospitals at Ft. Madison and Keokuk, Ia. 12 miles; 50 miles from Quincy. One prescription drug store. Office space available; equipment if desired. Financial assistance available. Predominant nationality: German and English. Agriculture and industry area. Churches: Catholic and Protestant. Beautifully located on Mississippi. Portion of the old Nauvoo being restored. One million dollars spent in preliminary steps. For further details contact: E. J. Kron, Nauvoo. Phone: 217-453-2717.

HENRY COUNTY: Geneseo; population: 6,000. Trade area, 20,000. Eight physicians, ages 33, 63, 38, 38, 58, 58, 63, and 65. Hammond Henry District Hospital located here. New hospital—$2,500,000, 110 beds—short term hospital—includes new 50 bed extended care section. Office space available. Predominant nationality: Swedish and Belgian. Agricultural community area. Located on highway Interstate 80. Eleven Protestant and Catholic churches. Grade and high schools. Local country club and swimming pool. For further details contact: Clement McNamara, Hospital Administrator, Geneseo.

IROQUOIS COUNTY: Danforth; population: 400. Trade area, 3,000. Nearest physicians at Gilman, Watseka, and Kankakee, 4, 18 and 25 miles. No physician for several years. Nearest hospital at Watseka, 18 miles, 60 miles from Champaign. Office space available. Financial assistance if desired. Predominant nationality: Dutch and German. Agricultural community area. Three Protestant Churches. Recreational facilities: golf, swimming, boating, flying and bowling. Town supported a physician for 60 years. For further details contact: Mr. Sebo S. Wilken, Mayor, Danforth.

IROQUOIS COUNTY: Gilman; population: 1,704. Trade area, 8,000. One physician in limited practice due to health. Two in nearby towns. Nearest hospitals at Watseka and Clifton, 12 and 14 miles. One prescription drug store; 50 miles from Champaign. Office space available. Predominant nationality: German. Agricultural area. Churches: Catholic, Methodist, Lutheran, Church of Christ, Presbyterian and Nazarene. Grade and high schools. For

further details contact: Miss Evelyn Marlett, Secretary, Chamber of Commerce, Gilman, or R. A. Buckner, M. D., Gilman.

JACKSON COUNTY: Ava; population: 650. No physician for 10 years. Nearest at Murphysboro, 15 miles. Nearest hospital, 15 miles; 75 miles from St. Louis. Office space available; financial assistance if desired. Agricultural and mining community. Churches: Protestant and Catholic. Grade and high schools. Kinkaid Lake to be constructed within short time by state and federal governments. For further information contact Mr. Ardell W. Kimmel, Secretary, Chamber of Commerce, Ava.

JACKSON COUNTY: Grand Tower; population: 850. Trade area, 3,600. Only physician died in 1964. Nearest physician, 19 miles; 90 miles from St. Louis. Office space available. Financial assistance if desired. Predominant nationalities: English, German. Agricultural community. Churches: Protestant and Catholic. Bus service to nearest high school. Good hunting and fishing. Sears Roebuck Foundation survey indicates community could support a physician well. For further information contact: Mrs. W. B. Lyon, Grand Tower. Phone 618-565-2682.

JO DAVIESS COUNTY: Elizabeth; population: 800. Trade area, 2,000. No physician since 1963. Nearest hospital at Galena, 14 miles; 34 miles from Dubuque, Iowa. One prescription store. Office built under supervision of Sears Foundation in 1958. Predominant nationality: German. Agricultural community. Churches: Protestant and Catholic. Grade and high schools. Nearest golf course, 8 miles. Good hunting and fishing in area. For further information contact: Mr. Lyle Francomb, Elizabeth, (815) 858-3727 after 5 p.m., or Marlo Specht, Elizabeth.

JOHNSON COUNTY: Goreville; population: 750. Six small towns in trade area without physicians. Nearest doctors at Marion and Vienna, 14 miles. Nearest hospital at Marion; 75 beds. Paducah, Ky., 60 miles. Agricultural area. Four Protestant churches. Grade and high schools. Fern Cliff State Park ½ mile. Lake of Egypt, 1½ miles. Good fishing and hunting in surrounding area. Federal prison, 8 miles. Goreville Boosters Club willing to give all possible assistance to a physician. For further information contact: Glenna Killey, Technician, Marion Memorial Hospital, Goreville, or Alma Ray, Goreville.

JOHNSON COUNTY: Vienna; population: 1,200. One physician, age 76; need for a second. Nearest hospitals at Metropolis and Marion, 20 and 32 miles. Two prescription drug stores. Remodeled and new office space available. Agricultural community. Nearby state hospital, security prison and glove factory to be opened soon. Grade and high schools. Nearest college at Carbondale. Churches: Protestant and Catholic. Organizations include Masonic Lodge, Kiwanis and Chamber of Commerce. Fast growing recreational area. For further information contact: Executive Secretary, Johnson County Farm Bureau, Vienna.

JOHNSON COUNTY: population: 7,000. County seat, Vienna, population: 1,200. No physician in entire county. Nearest hospitals at Metropolis and Anna, 20 miles, and Marion, 30 miles. Two prescription stores and a 49 bed nursing home in Vienna. Remodeled modern physician office with equipment including x-ray in Vienna. Agricultural community. Nearby state hospital. Minimum Security Prison in county, glove factory. Grade and high schools. Churches: Protestant and Catholic. Fast growing recreational area. For further information contact: Executive Secretary, Johnson County Farm Bureau, Vienna, 62995.

The following towns in the above-listed counties are also reported to be in need of additional general practitioners. For detailed information contact the county society secretaries shown below:

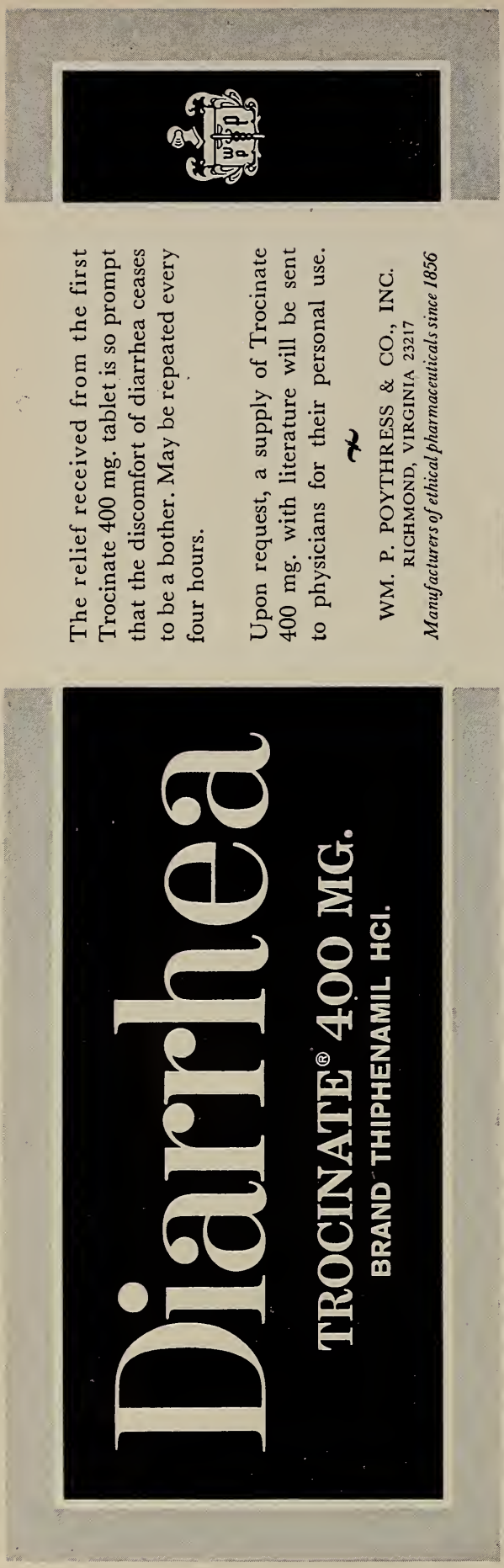
Hancock County: Plymouth
Ilse Erika Brueshel, M.D.
Warsaw.

Henry County: Galva
Fred Colby, M.D.
213 W. First St.
Geneseo.

Iroquois County: Onarga, Buckley, Cissna Park, Beaverville, Watseka and Milford
Ryland Buckner, M.D.
Gilman.

Jackson County: Carbondale
Homer H. Hanson, M.D.
P.O. Box 1030
Carbondale.

JoDaviess County: Galena
William G. Gillies, M.D.
300 Summit Street
Galena.



Matching Program

(Continued from page 576)

Residency Matching Program

Now that the National Intern Matching Program has become the National Intern and Resident Matching Program, matching programs for residencies as well as for internships are beginning to develop. The purpose of NIRMP is to conduct a national clearing office for matching the preferences of medical students for internships and of interns for residencies, both against the rank order of the preferences of the hospitals to which the students and interns have applied. In other words, matching programs will operate in much the same way that they have for internships.

The corporate members of the NIRMP are: The Advisory Board for Medical Specialties, The American Hospital Association, The American Medical Association, The American Protestant Hospital Association, The Association of American Medical Colleges, The Catholic Hospital Association and the Student American Medical Association. Representatives of these agencies plus representatives of the medical students, interns, and residents at large form the Board of Directors of the Corporation.

The U.S. Air Force, the U.S. Army, the U.S. Public Health Service, the Veterans Administration and the Association of Hospital Directors of Medical Education all have liaison representation upon the board.

"Cancer Detection: Routine Proctosigmoidoscopy," a new 20-minute color film, is now available for professional organizations, hospitals, clinics, etc. without charge from C. B. Fleet Co., Inc., P.O. Box 1100, Lynchburg, Va. 24505. This demonstration film was produced to help physicians perform a simple office procedure for early detection of asymptomatic cancer and adenomas of the colon and rectum. Over 44,000 persons in the U.S. die each year of colon-rectum cancer, according to the American Cancer Society. More than half of these deaths are needless and could be prevented by the use of the examination featured in the film.

Abstracts of Board Actions

(Continued from page 366)

MANDATORY TB TESTING

It was requested that with respect to mandatory tuberculin tests, approved by action of the House of Delegates, the Board support the Council on Scientific Services opinion that the action of the House of Delegates should be rescinded. The Council felt this would allow physicians to practice medicine according to their best judgment and remove the mandatory aspect in this area. It was the consensus that this was not within the power of the Board of Trustees, to rescind any action taken by the House of Delegates.

APPOINTMENT OF MEDICAL CONSULTANTS

The recommendation was adopted that the Board of Trustees request all State of Illinois agencies having medical consultants to appoint to each advisory panel at least one physician who is an active member of a corresponding or appropriate committee of the Illinois State Medical Society.

TWO-PIANO CONCERT TOUR SPONSORSHIP

The Educational & Scientific Foundation was granted approval for the sponsorship of a two-piano team to tour the state under the auspices of the Woman's Auxiliary, with all profits derived therefrom to accrue to the Foundation.





After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
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and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
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Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

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Fort Washington, Pa.

Instructing Pati To Inc

A revolutionary approach to alleviation of the health-manpower shortage has been announced by a newly organized firm staffed by specialists in medicine, communications, and learning, called Media Medica, Inc. (MMI). Its objectives, methods, products, and services were described at a press seminar held at the New York Academy of Medicine. It will be located at 555 Fifth Ave., New York, 10017.

The company's goal is to achieve an increase in physician productivity simultaneously with an improvement in patient care. To achieve this goal it is concentrating its activity in problem areas of medical service. Its focus will be on those medical conditions and situations which require repetitive patient counseling and instruction.

The availability of well-designed materials which the patient can take home for review will permit the physician to devote more time to individualized attention, thus improving both the quality of patient care and the doctor-patient relationship—while the physician is assured that the repetitive kinds of instruction are comprehended and followed, with a minimum of postinterview telephone calls and conferences for clarification.

To lighten the physician's load of patient counseling and at the same time improve quality and effectiveness, MMI will apply its talents to the development of patient-oriented learning aids. These will include scientifically designed and clinically validated instructional manuals, booklets, phonograph records, films, and other materials to supplement the physician's directions. Such counseling materials will be

"Horizons Unlimited," designed to tie in with the American Medical Association's paperback of the same name, has been produced in a 28-minute color film as a further means of encouraging young men and women to enter careers allied to medicine. It is the only recently produced film covering a broad variety of health career opportunities, zeroing in on 12 in particular, and is distributed through AMA headquarters.

ler MD Supervision– sician Productivity

available to patients only on prescription by their physicians. Patients will be motivated to follow the physician's instructions by assuring an understanding of a prescribed medical regimen. Other assistance to physicians will result from MMI's development of continuing education materials.

Also under development by MMI is a computerized service through which medical research information will be gathered, organized, evaluated and made available to hospital-based physicians.

While the problem of delivery of medical care is greater than ever, current advances in behavioral science and communications offer opportunities for solution that were never before available. All materials will be developed with precise instructional objectives aimed at proven needs for specific groups. Materials will be tested at all critical stages of development, and will undergo validation tests to assure that they achieve their instructional objectives.

Besides physicians, the audiences for various types and levels of material will be laymen of differing degrees of reading ability. Materials will also be designed to serve the medical and health needs of functional illiterates and non-English speaking people. Other materials will be developed to meet the special communications problems of patients in the ghetto areas and other deprived sectors of the population. Among the circumstances which brought MMI into being are the constantly growing number of patients, the shortage of physicians, and the scarcity of hospital beds, equipment and trained personnel.

We have great untapped sources of brainpower housed in handicapped bodies. Employers should realize that if an individual is properly trained and properly placed, his physical handicap will not be a job handicap..... Mrs. Jayne B. Spain, president, Alvey-Ferguson Operations, Hewitt-Robins, Inc.

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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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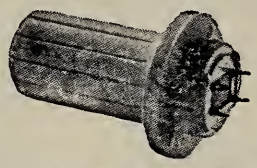
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Circulation Discovery

A discovery about the circulation of blood, which could lead to a better understanding of the mechanism of certain lung disorders, was reported at The University of Chicago during a Labor Day Weekend conference at the Center for Continuing Education. In addition to the University, other co-sponsors of the conference were Michael Reese Hospital and Medical Center, the Chicago Heart Association, and the Tuberculosis Institute of Chicago and Cook County.

Dr. Solbert Permutt, professor of environmental medicine at The Johns Hopkins University, said that a vast network of small blood vessels in the lung stand open and empty, ready to be filled with blood as needed. In medical terms, this is called recruitment.

While simple in concept, Dr. Permutt's finding helps explain a long-standing medical puzzle: just how does blood circulating through the lungs increase in volume in response to bodily needs? The old notion was that the large vessels in the chest increased in size and volume. Instead, Dr. Permutt has found that smaller vessels, just larger than capillaries, are involved.

Dr. Permutt's experiments in laboratory animals showed that recruitment occurs in response to alveolar pressure. The alveolae are the tiniest sacs in the lung, where oxygen from the air is exchanged with carbon dioxide from the blood.

Thus, when the lungs are fully inflated, all of the blood vessels which serve it are full of blood. In the dog, pulmonary blood volume can increase four times, from 100 milliliters to 400 milliliters.

"We have found," Dr. Permutt explained in a press interview, "that, together, the small vessels of the lung can hold more blood than can the large vessels."

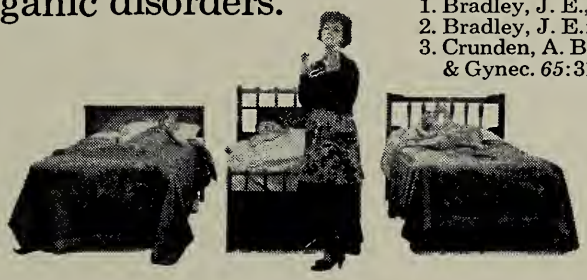
The finding, he explained, is intimately related to diseases of the lungs and should help explain pulmonary disease processes. For instance, if tiny blood clots called emboli lodge in the small recruitment vessels and block blood flow, pressure in the vessels could build up, forcing fluid to leak and causing edema, or fluid accumulation in the lungs. Another example would be the drug-induced constriction or tightening of these vessels at a time when they should be open.



Togetherness....

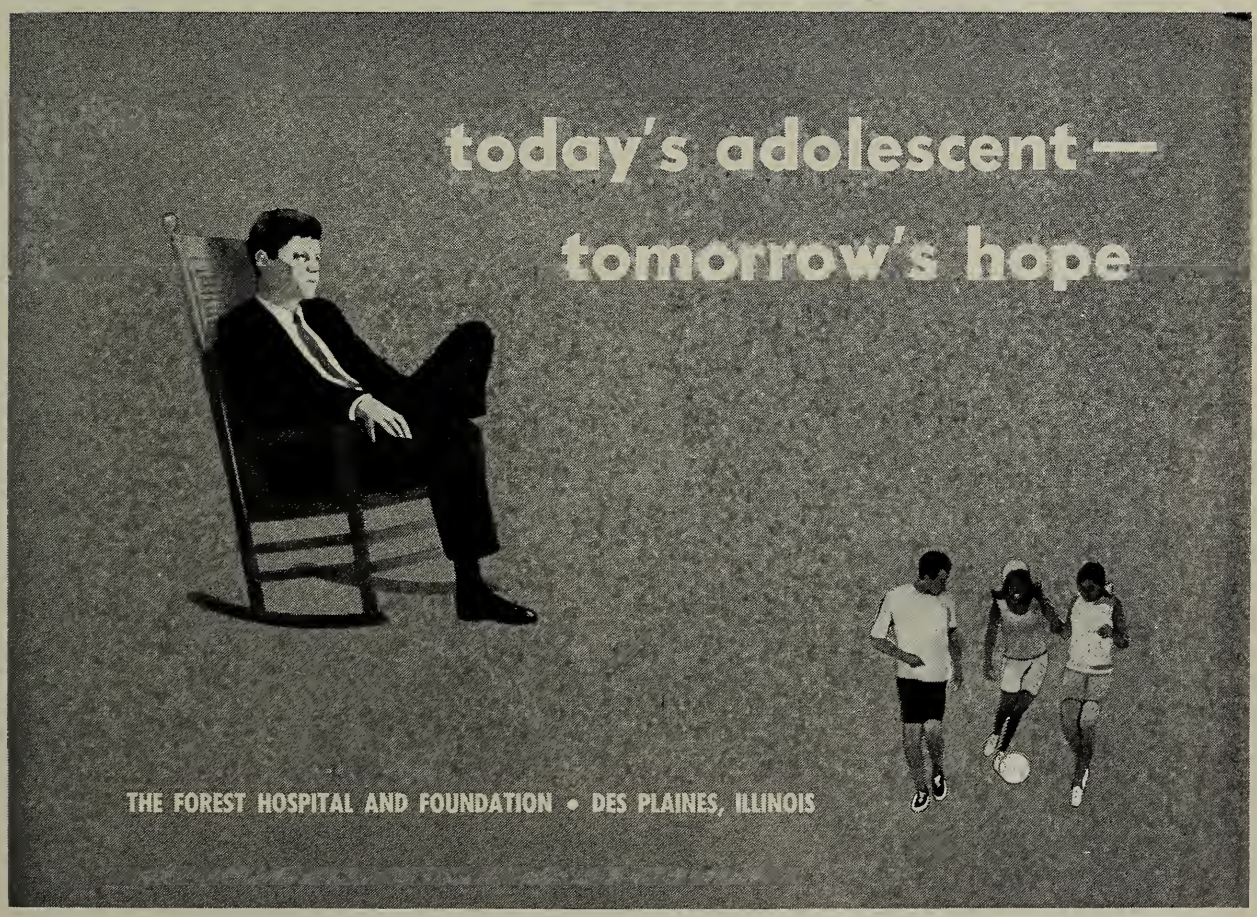
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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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A·H·ROBINS

Toxicity Laboratory Studies Air Pollution

Sulfur dioxide pollution of the air from burning coal is a growing health problem in American cities. According to Dr. Kenneth P. DuBois, Director of The University of Chicago Toxicity Laboratory, sulfur dioxide produced by coal burning adheres to coal dust particles and spreads through the urban air. These particles get into our lungs and create sulfuric acids.

The Toxicity Laboratory has been examining air pollution and its effects for two decades, in addition to conducting research on the modern environmental hazards of pesticides, radiation, and chemical agents. In its air pollution program, the Laboratory has concentrated on identifying toxic or poisonous agents, determining maximum allowable levels in circulating air. The Laboratory also samples atmospheric particle sizes to determine relative danger.

The Toxicity Laboratory was originally created during World War II to examine the effects of potential chemical warfare agents. "Many of the techniques and much of the basic information developed at that time," said Dr. DuBois, "is now being applied to the important current problem of environmental air pollution."

In addition to the insecticides, there is some evidence that solvents used in home aerosols can also affect detoxification systems in the liver and may be changing the susceptibility of man to drugs and other chemicals. The production of detoxification enzymes in the liver is a seemingly delicate process. It has been found recently that turpines in animal bedding affect the detoxification process and alter drug reactions.

In additional to studying interactions between pesticides and other chemicals, the Laboratory is testing potential antimalarial drugs. Drugs which might effectively combat malaria have to be studied to insure that they do not cause poisoning at the dosage levels needed to treat malaria. Dr. DuBois and his staff examine drugs submitted by U.S. Army researchers to determine the no-effect toxicity level. These tests then decide whether the dose needed to combat malaria is safe from the standpoint of toxicity to the patient.

BLUE SHIELD REPORT FOR Illinois Physicians

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 11 November, 1968

NABSP Membership Changes

The National Association of Blue Shield Plans at a special meeting October 8, in Chicago, amended membership standards to require that each Plan offer a Blue Shield program based on physicians' Usual, Customary, and Reasonable charges. In addition to this becoming a condition of Plan membership, the National Association's resolution also called for such programs to show evidence of professional support; contain provision for the development and maintenance of physicians' charges; and regular professional review and analysis of charges consistent with each Plan's responsibility to the profession and its subscribers.

In May 1967 the Blue Shield Plan of Illinois Medical Service sought approval of the Illinois State Medical Society's House of Delegates to offer contracts which would permit us to make payments to physicians based on Usual, Customary and Reasonable charges in accordance with the Society's definitions. The House of Delegates of the Illinois State Medical Society at its 1967 annual meeting approved of this method of payment to physicians which we applied August 1, 1967 for the first time in Illinois.

At the time Blue Shield gained support of the House of Delegates, we assured the Illinois State Medical Society that Usual and Customary charges would not become fixed but would be kept current by regular professional review and analysis of physicians' charges as they became available so that appropriate adjustments could be made.

The support of the Society's House of Delegates of payment to physicians on the basis of their Usual and Customary charges demonstrates a belief shared by Blue Shield that the best interests of physicians, their patients, and the financing mechanism will be served.

Usual and Customary certificates will not totally replace our existing indemnity contracts, but will offer greater choice to groups wishing broader protection. They provide an opportunity for members to have their medical costs prepaid on a more predictable basis with realistic payments to physicians for the services they provide.

The NABSP at the same meeting adopted a comprehensive scope of benefits which should be made available by member Plans no later than April 1, 1969. There was no implication that all Plans, national or local, will or should incorporate all the

Important Points to Speed Claims

1. Correct Certificate number as shown on the member's Blue Shield Identification Card.
2. Report services under only one Blue Shield Certificate Number.
3. Correct spelling of patient's and subscriber's names.
4. Correct age of the patient.
5. Designate place of service (hospital inpatient, hospital outpatient, office, home).
6. Include dates of service including date of admission and discharge from the hospital; date surgery was performed, if any; and number of daily hospital visits if for medical care.
7. Indicate if injury occurred at patient's place of employment.
8. Give details as to diagnosis, correct name of operation, if any, and sufficient descriptions, for example:

   Vein Ligations: Stripping, multiple resections, both greater and lesser saphenous, unilateral or bilateral.

   Lacerations: Location, length, depth and identify vessels, muscles, and tendons repaired, if any.
9. Check only the type of service you personally rendered indicating date(s) and description of the service(s).
10. Indicate your fee for each service you report and indicate whether the fee has been paid by the patient.
11. Personal signature of the Physician.

(continued)

benefits listed nor that the availability of comprehensive scope of benefits will necessarily alter a Plan's coverage.

The National Association urged Plan members to develop guidelines promptly to assure compatibility of benefits from Plan to Plan in an effort to coordinate benefits offered by the numerous Blue Shield Plans throughout the country.

We will be happy to discuss this matter with you at your Medical Society meetings, staff meetings, or answer questions you may have relating to our existing programs or future plans being developed to serve the best interests of the public and the profession.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Q What is "durable medical equipment"?

A Durable medical equipment is defined by the Soc. Sec. Adm. as "that equipment which (1) can withstand repeated use and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of illness or injury."

This category includes such items as wheel chairs, hospital beds, inhalators, iron lungs, commodes, and suction machines.

Q When is the cost of "durable medical equipment" covered for my patient?

A Medicare will pay the rental charges of such equipment (1) when it meets the definition of durable medical equipment and (2) when the equipment is necessary for the treatment of an illness or injury.

When a claim for such equipment is submitted by a patient, it must be accompanied by a statement from the attending physician giving the diagnosis and stating that the equipment is medically necessary for the treatment of the patient.

Q Why must specific dates of service be included on an itemized statement?

A Specific dates are necessary to determine the $50 deductible and to apply the allowable amounts to carry-over to the following year. Also the dates are used to avoid duplicate payments or disallowing legitimate claims. For example, a beneficiary may be hospitalized in June for a period of 10 days and have a Medicare claim submitted for medical visits. The same beneficiary may again be hospitalized in November for a period of 10 days. An identical medical claim would be submitted without dates of service. The November claim may be judged to be a duplicate of the claim submitted in June and payment would be disallowed.

Q When two physicians perform services simultaneously for the same patient, must each bill separately?

A Yes. In order to pay the claim, we must know the specific service rendered by each physician, the date of service and the charge for each service.

Q How do I file for Medicare and Public Aid benefits simultaneously?

A To file for both Medicare and Public Aid benefits, two copies of the SSA form 1490 must be prepared. In block 5 enter the patient's Public Aid number. Send one copy to the Medicare carrier and the other copy to the Department of Public Aid, Medical Unit, 1305 Outer Park Drive, Springfield, Illinois 62701. When Medicare payment is made, a copy of the Explanation of Benefits form will be sent to the Department of Public Aid for their further payment.

Submit 1967 Medicare Claims Now

The time is fast approaching when claims for services prior to October 1, 1967 will no longer be allowed. Any claim for services prior to this date must be filed on or before December 31, 1968.

The time limits established by the Social Security Administration for submitting claims for payment are as follows:

Claims for services provided from October 1, 1966 through September 30, 1967 must be submitted by December 31, 1968.

Claims for services provided from October 1, 1967 through September 30, 1968 must be submitted by December 31, 1969.

This process continues in such a manner that claims for services rendered prior to October 1st of one year must be filed by December 31st of the following year.

The cut-off date for claims in the first nine months of 1967 is drawing near therefore, we recommend that such claims be submitted for payment to the Medicare office as soon as possible.

Part B $50 Deductible Carry-Over

Any covered Part B Medicare expenses incurred in the months of October, November, and December which are applied toward the $50 deductible for that year will also be applied toward the deductible for the following year. Thus if Mr. X incurs no medical expenses for the year 1968 until the month of October and then has covered expenses of $50 during the next three months, these expenses will satisfy the deductible for 1968 and for 1969. As another example, the beneficiary may incur expenses of $20 prior to October and another $30 in November and December. The $30 will be applied toward the 1969 deductible as well as the remaining 1968 deductible.

The "carry-over" rule has been established to help the beneficiary who might otherwise have to meet the $50 deductible twice in a comparatively short period.

NOTICE

To help speed Medicare payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

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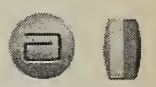


For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



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15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
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10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

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15 mg. Methamphetamine Hydrochloride,
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Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturers' package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

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DUPLICATE SINGLE PRODUCTS

FLUONID Corticoid-Local ℞
Manufacturer: Derm-Arts Laboratories (Div. Marion Labs.)
Nonproprietary Name: Fluocinolone acetonide
Indications: Adjunctive treatment of acute and chronic dermatoses.
Contraindications: Tuberculous, fungal, and most viral infections of the skin; hypersensitivity to it; not for ophthalmic use.
Dosage: Apply locally, two or three times daily as needed.
Supplied: Cream—0.01% and 0.025%) tubes of 15
Ointment—0.025%) and 60 gm.
Solution—0.01%, bottles of 20 & 60cc.

Histoplasmin Tine Test Diagnostic-Dermal ℞
Manufacturer: Lederle Laboratories
Nonproprietary Name: Histoplasmin
Indications: Diagnostic test for histoplasmosis.
Contraindications: None mentioned.
Dosage: One application on forearm.
Supplied: Individual test units, sterile.

PROSERUM 5 Hospital Solution ℞
Manufacturer: Pitman-Moore
Nonproprietary Name: Albumin, Normal Serum (Human)
Indications: Emergency treatment of hypovolemic shock.
Contraindications: None mentioned.
Dosage: To be determined individually.
Supplied: Vials-250 cc. (5% sol.)

COMBINATION PRODUCTS

BLUBORO Dermatologic Prep.-Other o-t-c
Manufacturer: Derm-Arts Laboratories (Div. Marion Labs.)
Composition: Aluminum sulfate
Calcium acetate
Boric acid
FD&C Blue #1
Indications: Relief of inflammed, ozing, and itching conditions of the skin.
Contraindications: None mentioned.
Dosage: Dissolve in water and apply as wet dressing.
Supplied: Powder-dual packets, cartons of 12 and 100.

(Continued on page 611)

New Pharmaceutical Specialties

(Continued from page 606)

FLUONID-N Corticoid-Local ℞
Manufacturer: Derm-Arts Laboratories (Div. Marion Labs.)
Composition: Fluocinolone acetonide 0.025%
Neomycin sulfate 0.5%
Indications: Adjunctive treatment of acute and chronic dermatoses in the presence of infection susceptible to neomycin.
Contraindications: Tuberculous, fungal, and most viral infections of the skin; hypersensitivity to any of the ingredients; not for ophthalmic use.
Dosage: Apply locally, two or three times daily as needed.
Supplied: Cream-tubes of 15 and 60 gm.

HISTASPAN-D Nasal Decongestant ℞
Manufacturer: USV Pharmaceuticals
Composition: Chlorpheniramine maleate 8 mg.
Phenylephrine HCl 20 mg.
Methscopolamine nitrate 2.5 mg.
Indications: Symptomatic relief of common cold, sinusitis, hay fever, and other allergic conditions.
Contraindications: Hypersensitivity to any of the ingredients, glaucoma, paralytic ileus, pyloric obstruction, prostatic hypertrophy.
Dosage: One capsule q.12h.
Supplied: Capsules, sustained release-bottles of 100.

RONDEC-C Nasal Decongestant ℞
Manufacturer: Ross Laboratories
Composition: Carbinoxamine maleate 2.5 mg.
Pseudoephedrine (equiv. to the HCl) 60 mg.
Indications: Adjunctive therapy in upper and lower respiratory tract disorders of allergic, infectious or non-specific etiology.
Contraindications: None known.
Dosage: Children: half to one tablet q.i.d.
Adults: one tablet q.i.d.
Supplied: Chewable Tablets-bottles of 100.

NEW DOSAGE FORMS

RONDEC-D Nasal Decongestant ℞
Manufacturer: Ross Laboratories
Composition: Each 1 cc. contains
Carbinoxamine maleate 1 mg.
Pseudoephedrine HCl 30 mg.
Indications: Adjunctive therapy in upper and lower respiratory tract disorders of allergic, infectious or nonspecific etiology.
Contraindications: None known.
Dosage: Infants: 0.25 to 1 cc. q.i.d.
Supplied: Oral Drops-bottles of 20cc.

RONDEC-S Nasal Decongestant ℞
Manufacturer: Ross Laboratories
Composition: Each 5cc contains:
Carbinoxamine maleate 2.5 mg.
Pseudoephedrine HCl 60 mg.
Indications: Adjunctive therapy in upper and lower respiratory tract disorders of allergic, infectious or non-specific etiology.
Contraindications: None known.
Dosage: Half to one teaspoon q. i. d.
Supplied: Syrup-bottles of 16 fl. oz.

Everybody has limitations, but what really counts are the abilities that remain. . . . . Dr. Clarence D. Selby, first medical director of General Motors Corporation.



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Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

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As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

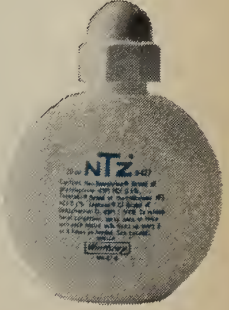
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

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Cause of Bacterial Flair-up Into Tuberculosis Study

Most types of mycobacteria are common and harmless. They may be found on leaves, in hay and in tapwater, for example. However, a few types cause serious disease such as tuberculosis.

There is growing evidence that under certain conditions even harmless mycobacteria can become harmful (virulent) causing benign cases of lymph node tuberculosis or tuberculosis of other organs.

Stephen E. Juhasz, M.D., associate professor of microbiology at Loyola University Stritch School of Medicine, will be studying the origin of the virulence with the support of a $5,980 grant from the Tuberculosis Institute of Chicago and Cook County.

Dr. Juhasz strongly suspects that a virus comes into play to convert the mycobacteria from harmless to harmful organism.

"It's not a simple mutation as once thought," he said. "I believe the virus becomes part of the bacterial genetic material, endowing it with virulence."

Dr. Juhasz notes that the same principle is involved in diphtheria. Viral infection of the bacillus is necessary for diphtheria to flare. Stop the virus and the bacilli will not cause disease.

AMA

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Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

ON THE COVER

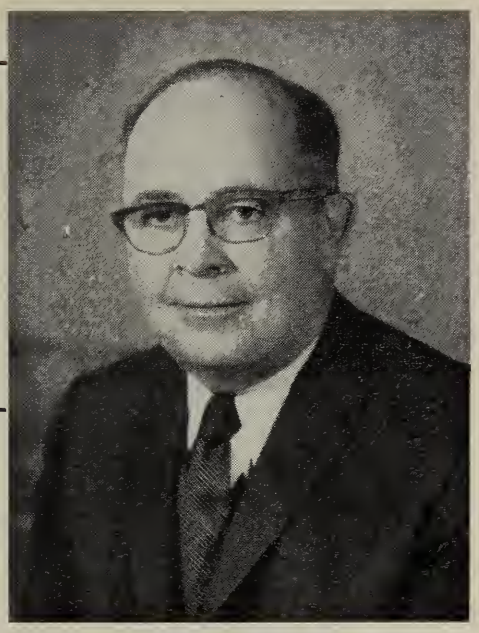
The autumn scene depicted on this month's cover may be found a short distance southwest of Chicago. The Old Graue Mill in Oakbrook is the last operating waterwheel gristmill in Illinois.

Surrounding the old village of Brush Hill (known today as Hinsdale), virgin farmland produced bounteous crops of grain in the early Illinois years. These were taken to this indispensable unit of the economy, the mill. Built in 1847-52, the mill stands on the site formerly occupied by a lumber mill destroyed in 1846.

One may visualize miller Graue on a long ago day showing off his fine mill to a rising young politician from down Springfield way, who had dropped in at the neighboring Castle Inn to pass the time of day, and perhaps discuss the burning question of slavery. For the German miller, who had sought freedom in the New World, had established in the cellar of the mill one of the few authenticated Underground Railway stations in Illinois.

But this is all of times past. We are reminded by the serenity and tranquility of the scene, by the antiquated equipment and quaint implements, of the good life we presently have. We are made aware of the tremendous progress which has been made in all of man's endeavors. We especially should feel humble and grateful for the many goodnesses experienced today.

The president's page



Philip G. Thomsen, M.D.

A Medical School For Southern Illinois

"What about a medical school for Southern Illinois?"

This was a pressing question among physicians—and other citizens—as we carried the ISMS President's Tour '68 into that part of the state.

And I have tried my best to answer it—although ISMS has taken no official position on the location of a next medical school.

Southern Illinois doctors are not expressing a "gimme" attitude in seeking "a piece of the action" for their area. Their position is selfless, earnest and idealistic, because it boils down to these two points:

1. The 31 southernmost counties generally are hardest-hit by the state's M.D. shortage.
2. Medical training facilities in that area would encourage graduates to practice there.

No one can deny these points . . . and I have said so.

The various suggestions offered for a med school in Southern Illinois deserve every consideration—from us, from our state government and from all Illinoisans . . . and I have said so.

Southern Illinois University has offered a proposal for a regional medical training program, which would use its educational facilities and Springfield clinics. And in Carbondale, I described that proposal as thoughtful and inspired.

Firm, solid action must be taken to relieve the medical pinch in the 31 southernmost counties. They have only one practicing physician per 1,450 inhabitants, according to a recent estimate. Statewide the number of doctors per capita is almost twice as high.

We are told that in Johnson County there were only two doctors, and both have moved away. That means 7,000 people without a local physician. Pulaski County, according to our figures, is the next hardest-hit, with only one doctor per 5,200 people.

Unless there is one doctor per 1,500 people, the public health is jeopardized. That's what the War Manpower Commission ruled in World War II.

Trained in big cities, Illinois doctors have gravitated to metropolitan areas. But many new M.D.'s would want to practice in our state's agricultural heartland if they could be trained in it . . . if they could absorb its way of life, its needs and wants.

In our membership survey of last August, we did not ask you where you wanted the proposed sixth med school for Illinois. We did not ask questions that could be construed as sectional in focus. However, there is no reason why we cannot ponder this problem—wisely and sympathetically. And in doing so, let us not think locally—but as Illinoisans and as members of a statewide medical society.

(Ed. note: after this writing Johnson County gained a physician.)

Philip G. Thomsen M.D.

Cancer in Pregnancy

A Northwestern University physician has reported studies of therapy using only drugs that dramatically reversed death rates in pregnant women suffering from a rare form of cancer.

John Brewer, M.D., professor of obstetrics and gynecology, Northwestern University, presented the results of his treatment technique for choriocarcinoma, cancer of the placenta, at the sixth National Cancer Conference held in Denver and sponsored by the American Cancer Society.

Standard treatment for cancer generally involves the use of surgery, radiation or drugs, or a combination of each. However, Dr. Brewer reported that the administration of the drugs alone, such as methotrexate and actinomycin-D, caused remission of the cancer and saved the lives of 75 women out of the 85 treated.

Before the development of this chemotherapy at both Dr. Brewer's laboratory and the National Cancer Institute, the disease (which could only be treated surgically) killed as many as 85 per cent of the women who contracted it.

Dr. Brewer followed the 75 survivors in a study lasting almost two-and-a-half years, and found that almost all had no ill effects. A number of them were able to have children again following the drug treatment.

The only other form of cancer which appears to respond to a "drugs-only therapy" is Burkitt's lymphoma, a cancer frequently involving the facial bones.

Past national death rates from choriocarcinoma, using the surgery-only treatment, were as high as 81 to 86%. Choriocarcinoma occurs in only one of 20,000 full-term pregnancies.

Future research by Dr. Brewer will center on possible genetic causes, stemming from broken chromosomes in placental cells, of choriocarcinoma.

The striking change that has taken place in America in our methods of earning a living, and the changes that are in prospect for the future, greatly improve our opportunities for utilizing the skills of the handicapped. There are more and more jobs to be filled, and there are fewer and fewer of them which require the physical dexterity which a handicapped person may not have.... W. P. Gullander, president, National Association of Manufacturers.

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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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IMJ
Illinois Medical Journal

volume 134, number 5 November, 1968

The Fight Against Smoking In Children

By Daniel J. Pachman, M.D./Chicago

The Role of the Physician

More children are smoking cigarettes, and at an earlier age, than ever before.

There appears to be a definite relationship between the smoking of cigarettes and the later development of lung and cardiovascular diseases.

Parental smoking behavior may have an influence on the smoking patterns of children.

The educational methods used to discourage smoking in school children are discussed.

Physicians should assume an active role in the fight against smoking in children.

Extraordinary progress has been made during the past thirty years in reducing the mortality rate of many of the diseases in infancy and childhood. These changes have been the result of a combination of various factors: (1) The introduction of chemotherapeutic drugs and antibiotic agents. (2) New and more effective immunization procedures. (3) A clearer understanding of the chemical balance of the body. (4) Advances in surgical techniques and pediatric anesthesiology. (5) Further advances in the treatment of the diseases caused by endocrine, genetic and enzymatic disorders.

Daniel J. Pachman, M.D., is Clinical Professor of Pediatrics, the University of Illinois College of Medicine, Chairman, Department of Pediatrics, Illinois Central Hospital, and is Associate Attending Pediatrician, Presbyterian-St. Lukes Hospital. He is president elect of the Illinois Chapter, American Academy of Pediatrics, and is a member of the Public Education Committee, the Illinois Division, American Cancer Society. Dr. Pachman has published extensively in the field of pediatrics and serves in numerous capacities in the cause of child care.

Admirable as the overall record appears to be, there are still a number of important pediatric health problems in this country which remain unsolved. Facilities and competent personnel for the care and treatment of behavior, emotional and mental disorders in children, are grossly inadequate. Accidents continue to be the foremost cause of death in children between one and fifteen years of age.[1] Fatal accidents in the first years of life have actually been on the increase since 1960.[2] The infant mortality rate (deaths from all causes under one year of age), a figure which is often used as an index of the nation's health, has remained almost stationary during the ten year period from 1956-65.[3] Drug addiction and venereal disease in the teen-ager has risen sharply during the past ten years. Gonorrhea has increased over 50% and syphilis has quadrupled in this age group.[4] As would be expected, congenital syphilis has increased markedly during the past few years.[5]

Cancer, a disease which takes a heavy toll in adult life, has now become the second most frequent cause of death in young children.[6] The leukemia-lymphoma group, and tumors of the brain and central nervous system account for almost two-thirds of the fatalities caused by childhood neoplasms. Though there are types of can-

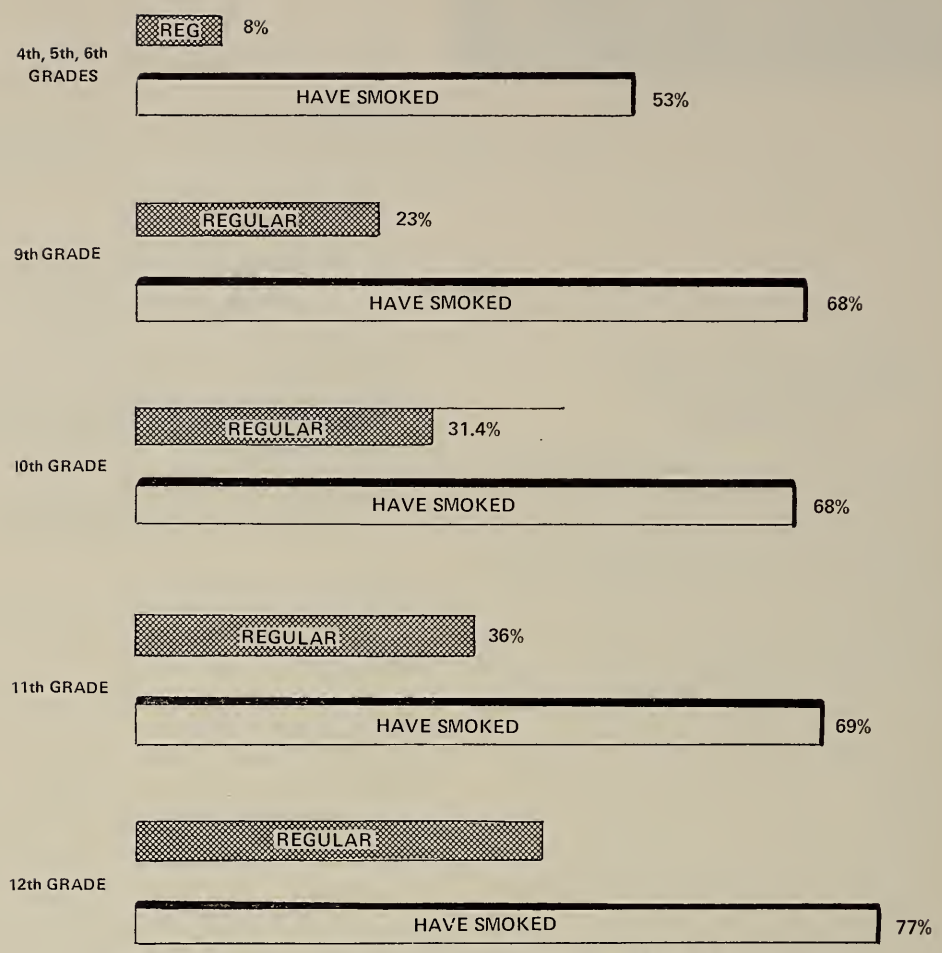


Fig. 1. **Source: Survey Conducted in Schools of a Number of Southern Illinois Counties Nov. 1967. Illinois Division, American Cancer Society.**

cer in children which, at the present time, cannot be helped, there are others which can be cured if the diagnosis is made early, and adequate treatment given. Then too, life expectancy has been prolonged in a small percentage of childhood leukemia patients for five years or even longer.[7]

Association Between Smoking and Cancer

Cancer of the lung, a disease which rarely causes death in childhood, has had a spectacular rise in adults and is now second only to diseases of the heart and blood vessels as a cause of death in the older age group.[7] Various reports have indicated that there is a close association between the smoking of cigarettes and deaths caused by cancer of the lung, and by cardio-vascular disorders.[8-11] During the past half century, since the introduction of cigarettes in 1910, there has been a marked shift from the smoking of cigars and pipes and the chewing of tobacco, to the consumption of tobacco by the smoking of cigarettes. Cigar and pipe smoke, which is heavy and alkaline, cannot be inhaled easily without coughing or becoming dizzy or nauseated. Cigarette smoke, on the other hand, is neutral and can be inhaled easily without discomfort. More than one-fourth of cigarette smokers inhale, in contrast with the very few cigar or pipe smokers who do so.[8] Those who begin smoking under the age of 21 years, according to a report of the Surgeon General's "Committee on Smoking and Health," inhale more, smoke more cigarettes, and run a greater risk of illness, disability and loss of life than those who begin later.[7]

Concomitant with the rapid rise in the consumption of cigarettes has been the

marked increase in the use of cigarettes by women and the introduction of smoking to young children of both sexes. A recent survey conducted by the Illinois division; the American Cancer Society, has revealed that more than half of the boys of the 4th, 5th and 6th grades of an elementary school in southern Illinois had already experienced the smoking of cigarettes. What was more astounding was that 8% of the boys were already regular smokers. The incidence of smoking in elementary and high school students in this locality increased through the higher grades to the point where over 40% of the boys were confirmed smokers by the time they reached the 12th grade (Fig. 1).

Another extensive survey recently completed in 1967, of the smoking habits of children in the Chicago Public Schools (465 schools—222,560 children), showed similar results—44% of the boys and 28% of the girls in the sixth grade had already tried smoking and 7% of the boys and 2% of the girls in that grade were smokers (Fig. 2). This same study also showed an increase in older students—42% of the 12th grade boys and 28% of the girls were smokers.

BY THE SIXTH GRADE A SIZABLE PROPORTION OF STUDENTS HAVE ALREADY TRIED SMOKING. SOME CONTINUE TO SMOKE.

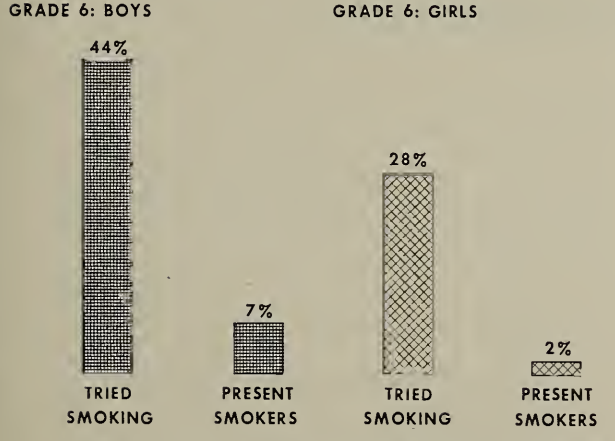


Fig. 2. **Source: Survey on Student Smoking Habits in the Chicago Public Schools. Chicago Chapter, American Cancer Society, Oct.-Nov., 1967.**

Effects of Parental Smoking

Parental smoking habits may have a profound effect on the smoking behavior of children. A research study in the Portland, Ore. high schools by Horn and his associates in 1959 revealed that when both parents smoked, 32% of the boys and 18.5% of the girls were regular smokers by the time they were in the senior class of high school. These figures were reduced by half when neither parent smoked. When only one parent smoked, there was a significant decrease in the incidence of smoking. The Horn study indicated that boys tend to imitate the smoking habits of their fathers, whereas girls tend to follow their mothers. When one or both parents stopped smoking, the rate of confirmed smokers in both boys and girls declined sharply. The smoking of cigars or a pipe by the father instead of cigarettes also tended to lower the incidence of smoking in his children[12] (Fig. 3).

A University of Illinois research team, in 1967, repeated the Horn study in the high schools of Rockford.[13] The findings of this group were very similar to those obtained almost a decade earlier in Oregon. However, the Rockford students showed higher smoking rates at the 9th and 10th grade levels, but lower in the 11th and 12th grades. The total smoking rate for grades 9 through 12 were identical in both studies. These investigators concluded that a higher percentage of school children are starting to smoke earlier today, as compared to a decade ago. The incidence of smoking in girls has also increased significantly in the 9th and 10th grade of high school. The Illinois Research group found, in contrast to findings in the earlier study, that the smoking behavior of children, both male and female, tended to follow very closely the father's smoking habits.

Trends in Mortality

Physicians, especially pediatricians, have long been leaders in the battle to lower the mortality and morbidity of childhood diseases. Many of us who have practiced pediatrics for over three decades, have had the warm satisfaction of witnessing dramatic changes in the prevention and treatment of illnesses which once exacted a terrible toll of children's lives or left them incapacitated. Yet, for some time, we have apparently ignored a health area which has become a major national problem. Eighty years ago, a male teenager had about 1 out of 500 chances of ultimately dying of cancer of the lung in adult life, whereas to-

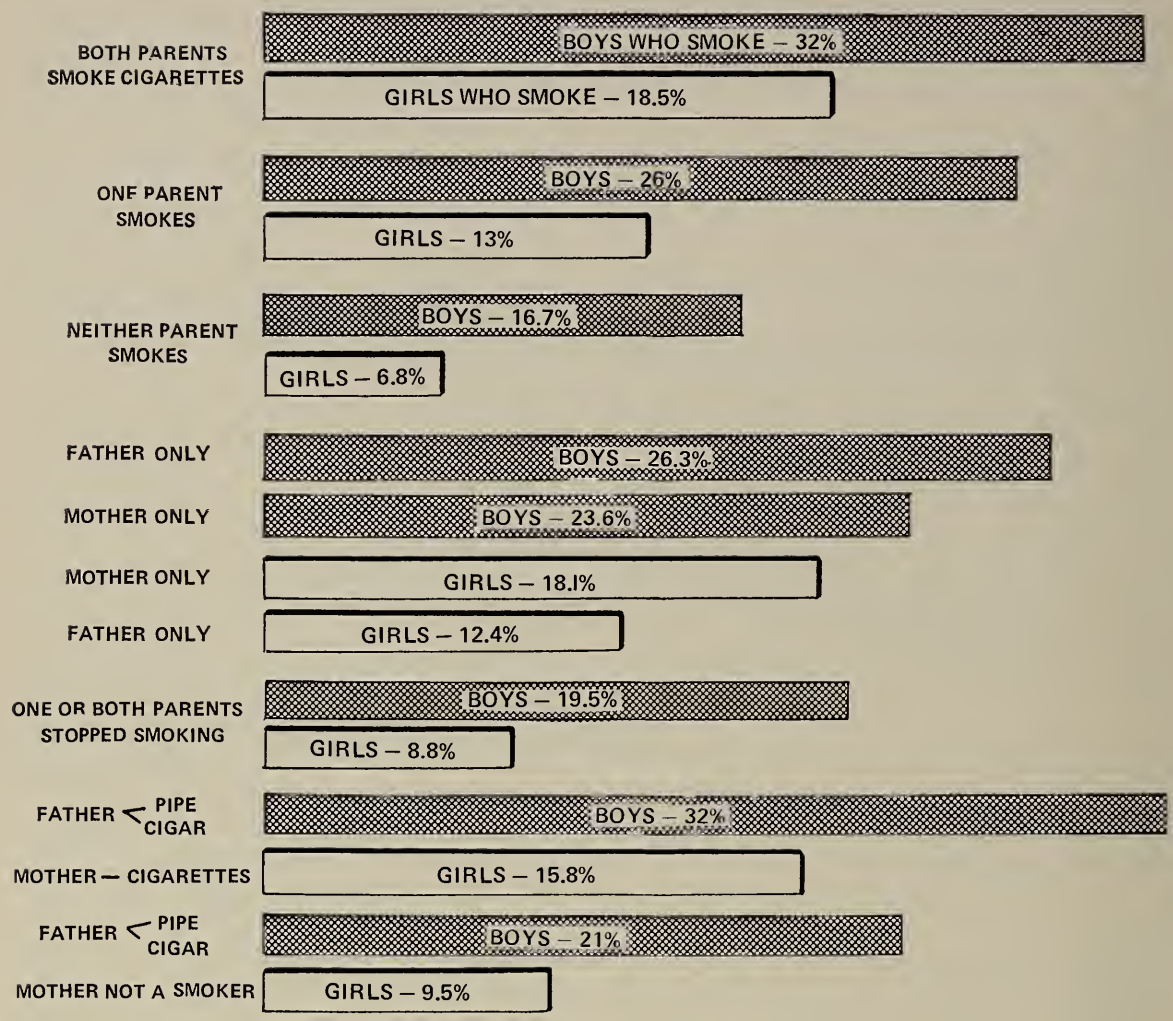


Fig. 3. **Source: Horn, D., et al[12].**

day, if the present rate continues, 1 of 7 male youths will succumb to this neoplasm. These startling figures still remain valid even though the changing age composition of the population is considered.[14]

Sufficient evidence has accumulated to implicate the smoking of cigarettes as a contributory, if not the most important factor in the development of lung cancer.[7,8] Organizations such as the Illinois Chapter of the American Academy of Pediatrics, and the Illinois State Medical Society, should bring the weight and prestige of their membership to bear in an intensive effort to reduce the number of children who will initiate the smoking habit.

If any appreciable progress is to be made in decreasing the percentage of children who will become regular smokers, then considerable attention also must be given to the following:

(1) the content of the anti-smoking propaganda materials used in the schools;

(2) the education methods employed;

(3) the optimum grade levels at which to present and stress these materials.

Children in lower grades of elementary school are not at all concerned with mortality or morbidity figures which show how early and prolonged smoking will affect them later in adult life. To them, the fourth or fifth decade of life is a long way off and they simply are not interested.

These same children may, however, be greatly influenced by selected informative audio-visual material (films, filmstrips, posters, etc.). At the First World Conference on Smoking and Health, which was held recently, it was strongly recommended that anti-smoking education should start as early as kindergarten.

The attitude of the teen-ager towards health matters differs considerably from the younger student. The adolescent is very much interested in health problems, particularly in the areas of personal health, (acne, dysmenorrhea, growth patterns, athletic injuries), sex education, smoking and the use of drugs, mental health (home conflicts, relation to parents, careers), and nutrition.

Suggestions for Discouragement Programs

Five main anti-smoking educational approaches have evolved, each with its own theme:[13]

(1) Contemporary message—this theme stresses the current effects of smoking (school children who smoke have more coughing and other respiratory disorders, are therefore less likely to become proficient in athletics or be leaders).

(2) Remote message—the effects of smoking on conditions occurring later in life (lung cancer, heart disease).

(3) Both sided message—this approach gives both sides of the smoking problem and lets the youngster make up his own mind about smoking.

(4) Authoritative theme—the influence of parent, doctor, teacher or coach is used to discourage smoking.

(5) Adult role-taking approach—the teen-ager acts as an adult to influence other adults not to smoke (father, mother, etc.); hopefully then, this may cause him not to smoke.

The results of the recent investigation of the Illinois research group in the Rockford schools indicated that the contemporary approach had the maximum effect in the reduction of smokers in these high school students. This is in direct contrast to earlier findings of the Horn study which favored the remote message. The Rockford study also found that the adult role-taking theme was more effective than the remote method.

The manner in which anti-smoking propaganda is presented to children at all age levels is also of great importance. There are two main techniques used: (1) the mass communication method; and (2) the student centered approach. In the mass communication method, a large section or the entire population of a school is exposed, at various times, to anti-smoking propaganda, delivered by experts. In the student centered approach, the children learn through a symposium of peer groups, in which they are all asked to participate. The Rockford study found that the contemporary message utilizing the student centered aproach was the most productive combination, particularly at the 8th grade level.[13]

Children are starting to smoke at an earlier age. This fact has been adequately documented by the recent Chicago School survey as well as the Rockford and South-

THE PROPORTION OF THOSE WHO TRY SMOKING AND CONTINUE TO SMOKE INCREASES STEADILY, PARTICULARLY IN GRADES 7-10.

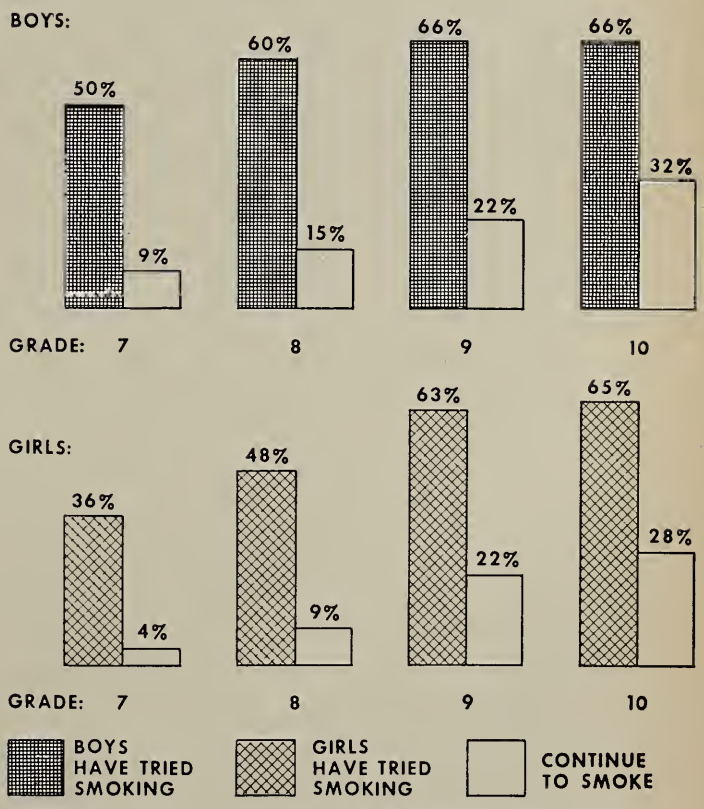


Fig. 4. **Survey on Student Smoking Habits in Chicago Public Schools. Chicago Chapter, American Cancer Society, Oct.-Nov., 1967.**

ern Illinois reports. The Rockford study showed that the 8th grade is the critical point at which male students will either become established smokers or ex-smokers. Girls however, usually smoke on an occasional basis for a longer time. The Chicago school survey also confirmed that the change from occasional smoker to smoker accelerates markedly between grades 7 through 10, and the trend was especially noted in young girls between the eighth and ninth grades (Fig. 4). It would appear from these findings that anti-smoking education should start with the first school experience or even earlier, and be stressed in the last two years of elementary school and the first year of high school.

What the Physician Can Do

What can the individual physician who treats children do to discourage the habit of smoking in his young patients? Physicians in their day-to-day contact with patients and their parents can be powerful instruments to disseminate meaningful information on the harmful aspects of smoking. The physician can point out to the parents how important is the effect of parental smoking on their children's smoking behavior. Since it has been shown that smoking starts at a very early age, physicians should take the lead in contacting and instructing responsible groups in their local elementary and high schools, and community youth organizations, in order to discuss with them the medical aspects of smoking and the methods to reduce the number of young smokers. Physicians should also support many of the leading health agencies in this country and abroad which have proposed the passage of legislation to regulate cigarette advertising on television and in other mass news media. The physician, himself, when talking with his teen-age patients on the subject of smoking, will find that these adolescents will respond more favorably to sound facts rather than strong admonition. The physician can also inform the parents of his patients (by periodic releases and office literature) of any new information on the smoking habit and its health consequences.[15]

Finally, all physicians should heed the following resolution on cigarette smoking, adopted by the Board of Directors of the American Cancer Society on May 5, 1967, and endorsed by the executive committee of the American Academy of Pediatrics, urging "(1) that physicians, dentists, nurses and other medical personnel do everything possible to reduce further cigarette smoking both by example and by advice. (2) The sale of cigarettes by medical and health institutions be discontinued. (3) That hospitals, clinics, health centers and physician's and dentists' offices discourage smoking."

Hopefully, then, with the combined cooperation and resolution of physicians, parents and young patients, we can ultimately make significant progress against the health hazards of cigarette smoking in children.

References

1. Various Reports of the National Vital Statistics Division National Center for Health Studies, Public Health Service.
2. Public Health Service Publication No. 600, Page 15, Revised 1967.
3. International Comparison of Prenatal and Infant Mortality, National Center for Health Statistics, Public Health Service, March, 1967.
4. Association of State and Territorial Health Officers, American Venereal Disease Association and American Social Health Association: Joint Statement on Today's V.D. Control Problem. (New York: American Social Health Association 1967.)
5. Alford, C. A. Jr.: Symposium on Intrauterine Infections, New York, N.Y. Jan. 10, 1968.
6. The Challenge of Childhood Cancer Ca. 1: 35-40 (Jan.-Feb.) 1968.
7. Smoking and Health, Report of the Advisory Committee to the Surgeon General of the Public Health Service. Publication 1103, 1964.
8. Hammond, E. C. The Effects of Smoking. Scientific American (New York) 207 (1): 3-15, July, 1962.
9. Doll, R. and Hill, A. B.: Lung Cancer and Other Causes of Death in Relation to Smoking. Brit. Med. J. 2:1071-1081 (November 10) 1956.
10. Hammond, E. C., and Street, E. C.: Smoking Habits and Disease in Illinois. Illinois Medical Journal 126:661-665 (Dec.) 1964.
11. Borloni, N. O., Hechter, H. H., Breslow, R.: Report of a 10 Year Followup Study of the San Francisco Longshoremen. Mortality from Coronary Heart Disease and From All Causes. J. Chronic Diseases 16:1251-1266, 1963.
12. Horn, D., Courts, F. A., Taylor, R. M. and Solomon, E. S.: Cigarette Smoking Among High School Students; American J. Public Health 49:1947, 1959.
13. Creswell, W. H., Huffman, W. J., Stone, D. B., Merki, D. J., and Newman, I. M.: A Replication of the Horn Study on Youth Smoking in 1967—Presented at a Joint Session of the American School Health Association and the School Health Section, American Public Health Association, Oct. 26, 1967.
14. Statistical Research Section, American Cancer Society.
15. The Health Consequences of Smoking, A Public Health Service Review, 1967. Public

Health Service Publication No. 1696, Revised 1968.

Educational Material on Smoking and Cancer, (posters, pamphlets, booklets, films, filmstrips, exhibits) suitable for showing at various school age levels can be obtained at the local offices of the American Cancer Society or at the Illinois Division Headquarters, at 37 South Wabash Ave., Chicago, Ill. 60603. Prepared lectures and slides are also available for interested physicians.

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For All Ages	Best Tip Yet (bookmark) Best Tip Yet (po) More Cigarettes-More Lung Ca (po) Athletes Posters, I Don't Smoke Cigarettes (6) (po) Smoking is Glamorous (po) Smoking is Sophisticated (po) Where There's Smoke (cartoon book)	Answering the Most Often Asked Questions (pam) Ca Facts & Figures (booklet) Free Teaching Aids (leaflet) Cigarettes & Health—A Challenge to Educators (fs) Working with Schools to Develop Programs on Smoking (Interagency Council) Smoking Poster Kit The Effects of Smoking (pam)
4th thru 6th grades	The Huffless Puffless Dragon (fl) I'll Choose the High Road (fs) I'll Choose the High Road (pam) Smoking is for Squares (cartoon reprint)	I'll Choose the High Road (Teacher's Guide) Student Questionnaire
7th thru 10th grades	Is Smoking Worth It? (fl) To Smoke or Not to Smoke (fs) Shall I Smoke? (pam) To Smoke or Not to Smoke (pam) The Great Imitators (pam)* We'll Miss Ya Baby (po)	To Smoke or Not to Smoke (Teacher's Guide) Teaching About Ca (bkl) Youth Looks at Ca (bkl) Student Questionnaire
High School, College, Teachers & Adults	High School, 7th thru 10th above if not previously presented Who, Me? (pam) Smoking & Health (pam)	Who, Me? (film presentation guide) Time for Decision (film discussion guide)*
High School, College, Teachers & Adults	Your Health & Cigarettes (pam) Lung Ca & Cigarettes (reprint) Who, Me? (fl) The Time to Stop is Now (fl) Time for Decision (fl) Time for Decision (fs) 300,000,000 Clues (fs) The Time to Stop is Now (slides & talk kit) Cigarette Smoking & Lung Ca Speakers' Charts (#2222.01) Congress Has Acted (po) If You Figure It's Too Late (po) Hoarseness or Cough (po) We'll Miss Ya Baby (po) To Smoke or Not to Smoke 3'x5' (ex) Lung Ca Prevention & the Physician 3'x5' (ex) The Time to Stop is Now 4'x8' (ex) No Smoking-Ca Control in Progress (signs) Fans Be Smart, Don't Start, The Time to Stop is Now, (Adults only) Glamour pocket card	Cigarette Smoking & Ca The Evidence (pam)* Presentation Reel (fl) Cigarette Smoking & Lung Ca Speakers' Kit (#2222) The Time to Stop is Now-Suggested Remarks for a Physician State Law Statistical Tables & Maps Selected References on Ca Smoking & Health (Summary of Surgeon General's Report) Smoking—The Great Dilemma (pam) To Help Implement the Surgeon General's Report (pam) Cigarette Smoking Among High School Students (pam) The Facts on Teenage Smoking (reprint) Modifying Smoking Habits in High School Students (reprint) Can We Help Them Stop (bkl on withdrawal programs) Student Questionnaire

(Bkl)=Booklet *(po)=poster* *(fl)=film* *(ex)=exhibit*
(Ca)=Cancer *(pam)=pamphlet* *(fs)=filmstrip* **=in production*

Doctors, Patients and Tranquilizers— Recent Developments

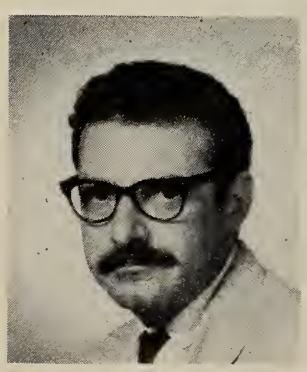
By Paul Lowinger, M.D./Detroit, Mich.

Family physicians in Iowa recently estimated that 18% of their patients have symptoms determined largely by emotional illnesses.[1] This tends to be confirmed by the 95 million prescriptions a year, 10 to 15% of the total, for tranquilizing and sedative medication. The major portion of the treatment of emotional disturbance is in the hands of the family physician and will continue to be so and this means the general practitioner, medical and osteopathic, the internist, pediatrician as well as others. The development of new classes of tranquilizing and energizing drugs since 1952 has made the family physician more effective and therefore more confident and interested in the psychiatric aspect of his practice. His patients and his community are more aware of his concern about emotional illness. Of importance has been the development of over 120 courses in post graduate medical education to extend and deepen the psychiatric understanding and education of the family physician.

We will cover three topics. First a discussion of the drugs themselves as they should be used in office practice. Second, the doctor will be treated as a therapeutic agent who influences the effect of the therapy. Finally, a follow-up of office patients with emotional disturbances treated with medication is offered which may serve as a clinical baseline. A new complete list of psychotropic drugs and dosage has been prepared by a colleague in pharmacology.[2] Another good source of detailed information is the 1965 edition of Goodman and Gilman.[3]

Any discussion of the drugs must refer to a clinical framework which includes a careful evaluation of the symptomatology, a diagnosis and a concept of the emotional background of the patient's problem. In gaining such perspective the physician will want to interview the patient and possibly his family and conduct a physical and laboratory examination. The decision may then be made that the patient does not require hospitalization, does not need referral to a psychiatrist, does not have a primary physical illness but rather has anxiety or depressive symptoms which require treatment. The Iowa family doctors treated 85% of their emotionally troubled patients themselves.[1]

The distinction between anxiety and depressive symptoms is a useful one despite the fact they sometimes occur together. The tranquilizing drugs which are used to treat anxiety symptoms may be divided into major and minor tranquilizers. The major tranquilizers, or antipsychotic drugs are distinguished by their effect on schizophrenic symptoms and their production of neurological side effects. They are the phenothiazines, reserpine and other rauwolfia alkaloids and the butyrophenones such as Haloperidol. The minor tranquilizers which are of little value in treating psychosis are antianxiety drugs which have some pharmacologic similarities to the barbiturates. They differ from barbiturates chemically and pharmacologically because they relieve more anxiety with less sedation. Most prominent in this group have been meprobamate and the benzodiazepines



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which include Librium and Valium. There is a whole group of anti-depressant medications used to treat mood depression which include the sympathomimetic drugs such as dexedrine, the monoamine oxidase inhibitors and the tricyclics.

Selection of Medication

The selection of the right medication for the patient is of considerable importance despite the placebo effect which we will talk about later on. If the patient who is presenting with anxiety symptoms has a schizophrenic illness, he will do better on tranquilizers of the anti-psychotic class. Your ambulatory schizophrenic patient is a candidate for phenothiazine medication. The most useful phenothiazine is still Thorazine which is started at 25 mg. three or four times a day but may be raised promptly to 100 mg. three or four times a day. Thorazine diminishes hallucinations and delusions as well as reducing the reaction to all stimuli. With 12 phenothiazines available, each of us need be familiar with only two or three. The parkinsonian side effects of Thorazine may be controlled with Cogentin given .5 to 1 mg. a day. The presence of mild extrapyramidal symptoms is evidence of absorption of the drug. If the parkinsonian symptoms are severe, Mellaril with the same dosage as Thorazine may be substituted. The piperidyl derivatives of the phenothiazines such as Mellaril cause less parkinsonian rigidity and tremor but more autonomic side effects including delayed ejaculation, dizziness and nausea. Phenothiazines with piperazine side chains such as Stelazine are more useful for apathetic schizophrenic patients with a thinking disorder. Stelazine is given in doses of 4 mg. two or three times a day. Thorazine and Stelazine may be used in combination.

Should the phenothiazines be used with the anxious non-psychotic patient? There is no indication that they are superior to the milder tranquilizers and they have a greater incidence of side effects and are not as well tolerated in the non-psychotic patient. In other words, the phenothiazines can be restricted to the anxious psychotic, whether he is an inpatient or an outpatient.

In general chloropromazine and the other phenothiazines have proven to be quite safe despite the concern about jaundice and agranulocytosis soon after their introduction in 1954. The jaundice is a hypersensitivity manifestation resulting in cholestasis in the center of the liver lobule without parenchymatous damage. If this occurs, discontinuation of the drug and the substitution of a different phenothiazine has been satisfactory. Like jaundice, the rare agranulocytosis has occurred within the first month of the administration of the drug, and most often in older women with low white blood cell counts. There has been some skin hypersensitivity with an urticarial reaction early in treatment which clears following discontinuation of the drug. The skin may remain clear even if the same phenothiazine or another one is reinstituted. A few patients on phenothiazines have a marked photosensitivity so that they have to stay out of the direct sunlight. Other reactions which are usually handled by an adjustment of dosage include faintness, palpitation, nasal stuffiness, dry mouth and drowsiness. There have been reports about pigmentation of the skin and opacities of the lens and the cornea after years of phenothiazine treatment. The synergism between phenothiazine and other drugs including barbiturates, alcohol and morphine is worth noting.

Minor Tranquilizers Noted

The most useful of the minor tranquilizers in our experience has been Librium. This is ordinarily given in 25 mg. doses three or four times a day. Other minor tranquilizers with effect in the anxiety-tension area include meprobamate and the Librium analogues, Valium and Serax. These medications cause considerably less sedation than the barbiturates although there is some risk in a Librium patient driving a car until adjustments to the medication have occurred. While these drugs are chemically and pharmacologically distinct from barbiturates, they do suppress the barbiturate abstinence syndrome in animals. The anti-anxiety drugs have little effect on mood depression or on psychotic symptomatology and do not cause parkinsonian symptoms in the usual doses. Meprobamate is ordinarily given 400 mg. four times a day.

It is important to emphasize the use of an adequate dose with each of the drugs we have discussed. The dose recommended by the manufacturer in the Physician's Desk Reference may be inadequate. Spreading the dose throughout the day and giving the last one at bedtime may eliminate the need for a sleeping medication. However, Doriden

or one of the other non-barbiturate hypnotics may be used for sleep in patients taking tranquilizers. It should be noted that while addiction has been reported with Librium and meprobamate, like suicide it is much less common than with barbiturates.

Depression Medications

The anti-depressant medications should be mentioned even though they are energizers rather than tranquilizers. We see ambulatory patients with mood depressions that are part of a mild manic depressive illness, involutional reactions, psychoneurotic depressive reactions, depressions during situational reactions or an exacerbation of characterologic difficulties. Whenever a depression reaches the point of physiologic significance, that is, sleep disturbance, appetite loss, lack of energy, slowing of activity and loss of interest, it is likely that anti-depressant medication will be of value. Where the depression is not accompanied be some of the physiologic symptoms, it is unlikely the medication will be useful.

The presence of "masked depression" has been frequently reported. In this situation the patient's gastrointestinal or cardiovascular symptoms are not organically determined but are psychogenic. However, they serve not just to hide or defend against emotional conflict, but also to disguise the presence of a mood depression. It is often the patient who complains of gastrointestinal symptomatology and who denies depression but admits to being under emotional stress who makes an unexpected suicide attempt.

Our drug of choice in mood depression is Tofranil which was the earliest of the tricyclic anti-depressive agents. It is ordinarily started in doses of 25 mg. three or four times a day but may be used up to 200 mg. a day. Anti-depressant medications including Tofranil require from two to six weeks before they have an effect. The modification of Tofranil as desimipramine appears to have little advantage. Elavil is one of a similar class of compounds, the dibenzocycloheptadienes, which may be substituted for Tofranil. Elavil causes some relief of the anxiety associated with many depressions. If the depressed patient is agitated or anxious and one wishes to use Tofranil, it may be combined with chloropromazine or Librium. This combination may not be necessary when using Elavil which is also started at 25 mg. three or four times a day.

Another reason for our preference for the tricyclic drugs in depression is that they have much less toxicity than the MAO inhibitors. Where depressions are refractory to the tricyclics, one can shift to Niamid, 25 mg. three or four times a day. Most potent of the MAO inhibitors is Parnate. It is used with psychiatric inpatients but may be suitable for difficult depressive illnesses in outpatients in doses of 10 mg. two to three times a day. The concern about hypertensive crisis has lead to caution with Parnate which should not be used with tyramine-containing cheeses because of the pressor effect. In general, different classes of anti-depressant agents should not be combined and several days should elapse if a patient is shifted from a tricyclic to a MAO inhibitor. At least a week should elapse between the discontinuance of a MAO inhibitor and the initiation of the Tofranil therapy since the combination has produced convulsions, coma and hyperpyrexia. Like the tricyclics, the MAO inhibitors may be combined with Librium or a phenothiazine to control anxiety. The toxic symptoms attributed to Tofranil include dry mouth, sweating, constipation, dizziness, tachycardia, headache, palpitations, blurred vision, tension and tremor and urinary retention; however, these effects are quite infrequent and usually mild. The absorption of the drug and the adequacy of the dosage may be judged by the presence of atropine-like actions such as a dry mouth.

Studies with depressed patients still show that electroshock treatment is effective in a higher number of patients than any of the drugs.

Physician Role Discussed

What about the role of the physician himself as a therapeutic agent? Let us consider the placebo in relationship to the doctor. According to Houston[4] writing in 1938, there is no medication of any specific value in the pages of Hippocrates and this remains true for over a thousand years. Despite the presence of an occasional medication of physiologic value such as the use of fresh fruit for scurvy in 1753, the use of medication has been largely on a scientific basis in the last 70 years. How was it possible for the physician to hold an honored place for thousands of years if his medications were worthless? The enthusiasm, confidence

and faith of the patient led to many therapeutic successes in which the doctor himself was the agent. The revival of interest in the placebo begins with the anesthesiologist, Beecher, who taught us that the pain relief of post surgical was 30% due to a placebo reaction and 40% due to a physiologic effect of morphine which made a 70% effectiveness.[5] A summary of 15 studies of the placebo in 1955 showed its therapeutic effect to be about 35% in a great variety of conditions ranging from wound pain to angina pectoris and sea sickness.[6]

Our comments on the effectiveness of the physician as a therapeutic agent come from observations of the effects of placebos and tranquilizers in our drug clinic[7] which functions very much like the office practice of a family doctor. We treat ambulatory psychiatric patients after a complete evaluation by visits of 15 minutes duration once or twice a month with one of our resident physicians. The use of rating scales and symptom scores allow us to measure the effects.

The placebo effects in four one month double-blind studies conducted in order to evaluate tranquilizers between 1959 and 1964 have varied from 24 to 76% patient improvement.[8] This represents a 300% variation in the therapeutic potency of the placebo control during a five year drug treatment-evaluation program that remained essentially the same except for the variables that will be discussed. The studies were double-blind because neither the patients nor the physicians knew whether the patient was receiving a placebo or an active drug although the doctors knew which active drugs were being employed. Just as interesting as the variability in the placebo groups containing 17 to 26 subjects was the fact that the effects of the active drug in each group tended to parallel the placebo. The low placebo response study of 24% was obtained with an unknown drug with mild skeletal relaxing properties and some tranquilizing effects, Trepidone. The resident physicians involved in this study regarded the active drugs as one of low potency and without a reputation for producing either impressive therapeutic results or toxicity.

The patients in this study were not given psychological tests or additional examinations beyond the brief visit with the doctor. Like its placebo, Trepidone produced a 30% repsonse rate. The other low placebo, 35% patient improvement, occurred in a study without psychological testing but a comparison to low daily doses of Stelazine, 4 mg.; Librium, 40 mg., and meprobamate, 1600 mg. Like the placebo, Stelazine produced an improvement rate of 32%, meprobamate 29% and Librium only 16%. The high placebo response rate was 76% which occurred in a double-blind study with the same agents when they were raised to adequate daily levels, Stelazine, 8 mg.; Librium, 80 mg., and meprobamate, 3200 mg. There was a small amount of psychological testing. Now the Stelazine produced a remission rate of 67%, Librium 87% and meprobamate 44%. The other high placebo study, 74% involved two mild drugs, Suvren which has since been discontinued and sodium amytal which is not a tranquilizer. In this study each patient was subject to a great deal of testing involving two hours with a research assistant at each visit and also a Funkenstein mecholyl test. Like the placebo in this study, the sodium-amytal produced an improvement rate of 78% and Suvren 60%. These results point to the importance of the doctor's attitude toward the medications he is using even in a double-blind study. It also shows the involvement of the patient with the emotional experience of the clinic program even when this is conveyed by a research assistant performing psychological tests or a nurse injecting mecholyl and measuring blood pressure.

Psychopharmacology Results

What kind of results can we expect from psychopharmacology in our outpatients? The drug clinic program at the Lafayette Clinic in Detroit used a great variety of tranquilizing and energizing medications for anxiety and depressive symptoms in conjunction with 15 minute interviews between 1956 and 1959 before we began our double-blind studies. Psychiatric residents saw the patients for adjustment of medication, review of symptomatology and consideration of toxicity once a month. Drugs such as chloropromazine in the tranquilizer class and Deaner and Tofranil in the energizer class were in use. A follow-up of 118 out of 157 patients, 80%, was performed 14½ months after they terminated outpatient drug treatment.[9]

A review of the data showed that at the time of the termination of drug treatment,

65% of the patients were in remission or improved while 35% were essentially unchanged or worse. At the time of follow-up 14½ months later, 52% of the patients remained improved. It should be noted that not all of those who were improved at termination remained improved at follow-up. The patients averaged 4½ different drugs during the time they were in treatment which averaged nine visits in nine months. No difference in results were seen by diagnostic groups which included schizophrenia, psychoneurosis, character disorder and the manic depressive, depressed and the involutional reaction as the fourth group. The only difference was that the improved schizophrenic patients had an average of 13 visits while the other improved patients had an average of nine visits. The patients averaged 36 years of age and 60% of them were women; however, sex, age, marital status, the number of drug clinic visits, the number of different medications received and the frequency of change of the drug clinic doctor did not influence the results of treatment at either time the patient termined or at time of follow-up. The 53% of patients who terminated by mutual consent with the doctor were no different in improvement rate from the 47% who stopped by not keeping appointments and offering no explanation.

Summary

Obviously this is not the whole of office psychopharmacology. We have said nothing about a great many topics which are of considerable concern: pediatric psychopharmacology including amphetamines in hyperactive children, the maintenance of the chronic manic depressive on lithium or anti-depressant medication, continuous phenothiazine therapy in the chronic schizophrenic, the treatment of the alcoholic and the sedation of the agitated senior citizen.

I suggest that one should consider my views in the light of one's own experience. First, become familiar with three phenothiazines for psychotic patients, a minor tranquilizer or two for anxious nonpsychotic patients, and anti-depressant agents for the depressed. Second, recognize the therapeutic effect of the contact with the physician and third, evaluate results in the treatment of emotionally disabled patients.

References

1. Finn, R. and Huston, P., "Emotional and Mental Symptoms in Private Medical Practice, *Journal of Iowa Medical Society,* 56:138-143, 1966.
2. Domino, E. F., "Classification of Psychoactive Drugs", 1967.
3. Goodman, L. and Gilman, A., *The Pharmacological Basis of the Therapeutics,* MacMillan, New York, 1965.
4. Houston, W., "Doctor Himself as Therapeutic Agent", *Ann. Int. Med.,* 11:1416, 1938.
5. Lasagna, L., Mosteller, F., von Felsinger, J. and Beecher, H., "A Study of the Placebo Response", *Am. J. Med.* 16:770-779, 1954.
6. Beecher, H., "The Powerful Placebo", *J.A.M.A.* 159:1602-1606, 1955.
7. Lowinger, P., Schorer, C., Knox, R. S., "Psychological Implications of Outpatient Drug Therapy", *The Dynamics of Drug Therapy,* Ed. Sarwer-Foner, G., 471-483, Charles Thomas, Springfield, 1960.
8. Lowinger, P., and Dobie, S., "What Makes the Placebo Work? A Study of Placebo Response Rates", presented at Divisional Meeting of American Psychiatric Association, Honolulu, August, 1965.
9. Lowinger, P., Dobie, S., Reid, S., "What Happens to the Psychiatric Office Patient Treated With Drugs? A Follow-up Study", *Psychiatric Quarterly,* 41:536-549, 1967.

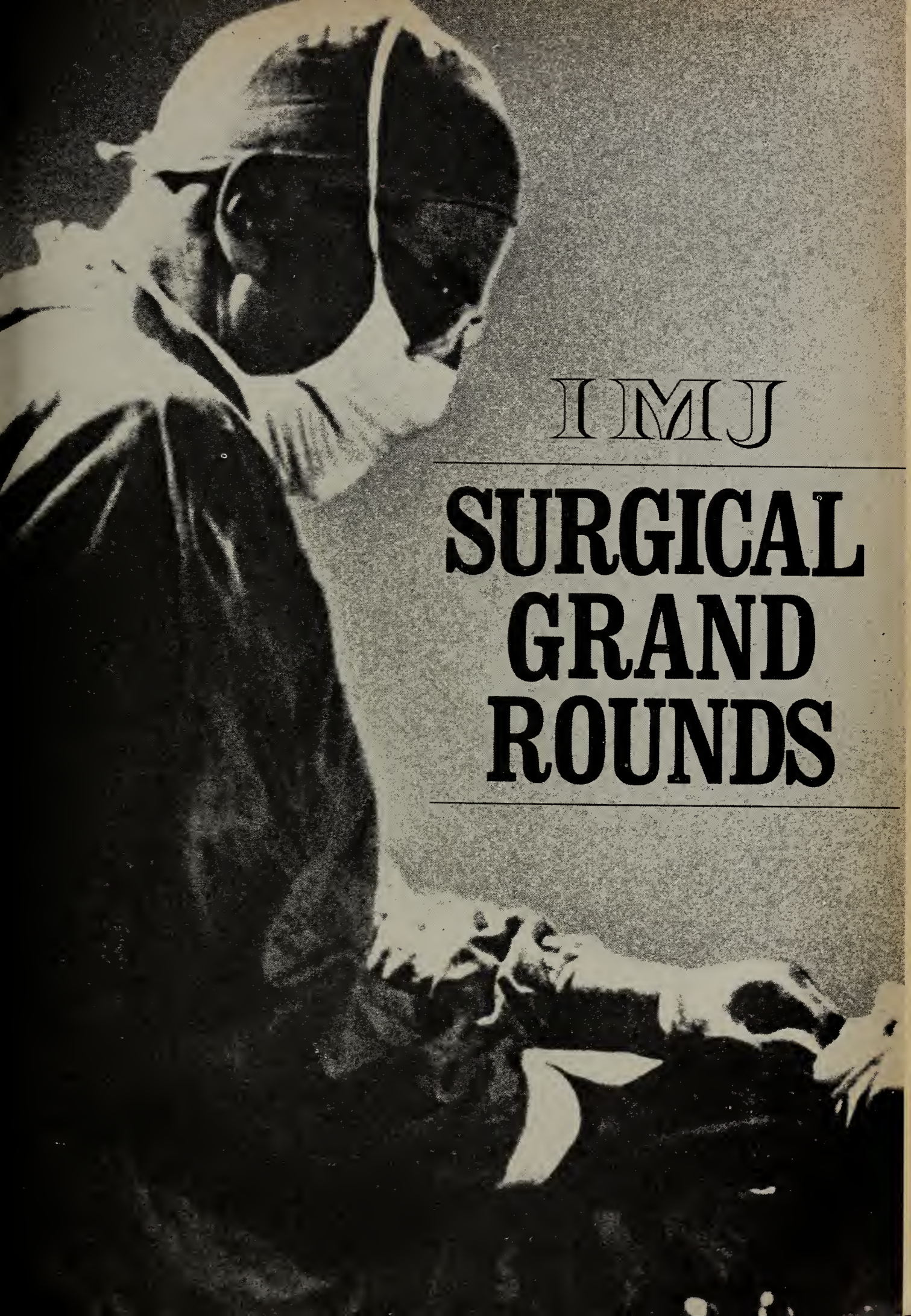
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SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on February 10, 1968.

Hypertension and Ileus

Case Presentation:

Dr. Joseph Sherman: The patient is a 47 year old white male truck driver, who was admitted to Veterans Administration Research Hospital Jan. 10th. Approximately one year ago he began having palpitations, nervousness, excess sweating, and occipital headaches. These episodes were usually precipitated by heavy labor or by anxiety, and each lasted about one hour. Relief was usually obtained by resting. Two weeks before admission he jumped from the cab of his truck, a distance of about three feet, and twisted his left ankle. Twelve hours after the accident he went into the emergency room of a hospital, and while there he developed nausea, vomiting and abdominal distention. Because of these symptoms he was admitted to the hospital. At this time his blood pressure was found to be 268/110. The examination was otherwise unremarkable except for marked abdominal distention and absent bowel sounds. An ECG was obtained which was reported to suggest a recent myocardial infarction. He was treated with intravenous fluids, digitalis and Peritrate. Because of the history of episodes of flushing and the elevated blood pressure, a 24 hour urinary V.M.A. excretion was obtained, which was 68.5 mg. (normal 9 to 10 mg.) He was then transferred to the Veterans Administration Research Hospital where his blood pressure was 260/120. He had marked abdominal distention and absent bowel sounds. Neither cafe-au-lait spots nor neurofibromata were present. Each flank was massaged without elevation of the blood pressure. Past history: physical examinations in 1966 and 1967 were said to be normal. A familial history of hypertension was not obtained.

A naso-grastic tube was inserted and parenteral fluid was administered. The patient improved with this conservative therapy and oral feedings were taken after a week. The day after admission a Regitine test was performed. Approximately two minutes after the injection of Regitine, his pressure dropped from 240/125 to 155/80, but five minutes later returned to the previous abnormal level. The day after admission 24 hour urinary excretion of catecholamines was determined and was 5,900 micrograms (normal less than 103 micrograms). His blood pressure remained elevated for nine days, then returned to

normal levels. A number of radiologic studies have been performed.

Dr. Hirsh Handmaker: The admission films were four views of the abdomen and showed an absence of dilation of the large and small bowel, but some separation of the loops of the bowel, suggesting edema. The picture of generalized gas, seen in the distal colon and rectum, as well as stacked small bowel, is compatible with an obstructing lesion in the region of the anus as well as severe ileus. The intravenous pyelogram showed bilateral symmetrical filling of the upper urinary tract without any obstruction, and good calyceal systems, except for the upper pole of the right kidney, was not well visualized. One view suggested a mass in the right suprarenal area. The perfusion nephrotomogram, performed twice, failed to demonstrate a mass in the right suprarenal region. The upper calyceal system was not well seen. This is considered to be a normal perfusion nephrotogram.

Patient enters.

Dr. Sherman: Could you just describe one of the attacks you had? How would these start and what were they like?

Patient: Usually when I would get excited or worried, I would start sweating and coughing. Then I would sit down for an hour or an hour and a half and would cool down. I could feel my heart going real fast. Also I had headaches in the base of my head.

Patient leaves.

Dr. John Colwell: This patient had a classical history for pheochromocytoma. After the stress of his knee injury, he had a severe attack of nervousness, sweating, and headache. This progressed to nausea, vomiting and paralytic ileus. This latter complication is unusual in pheochromocytoma and represents the vasoconstrictive effects of catecholamine excess on bowel vasculature. This is an important complication of pheochromocytoma to recognize and to treat medically. Premature surgical intervention for a surgical abdomen could have been lethal in this case.

The internist is faced with the evaluation of large numbers of patients with hypertension. Because pheochromocytoma is a remediable cause of an elevated blood pressure, it must be ruled out in all cases of hypertension. This may be screened by indirect tests and diagnosed definitively by direct measurement of the excretion of urinary catecholamines and their metabolites. Of the indirect tests, the use of intravenous phentolamine (5 mg.) has been the most valuable in hypertensive subjects. As in this case, a fall in blood pressure greater that 35/25 mm. of mercury shortly after intraveneous phentolamine is suggestive of pheochromycytoma. Falsely positive responses may occur in patients who are azotemic, on sedatives, anti-hypertensive agents or tranquilizers. There are several provocative tests for pheochromocytoma, but these should be used sparingly because of the possibility of provoking a hypertensive crisis.

The direct tests of the excretion of catecholamines or their metabolites have supplanted the indirect tests for definitive diagnosis because of the improved accuracy and specificity. There are biochemical methods for measuring norepinephrine (NE), epinephrine (E), normetanephrine (NMN), metanephrine (NE), and vanillylmandelic acid (VMA) in 24 hour urine specimens. The formulas and a simplified metabolic scheme for these compounds are as follows (Fig. 1):

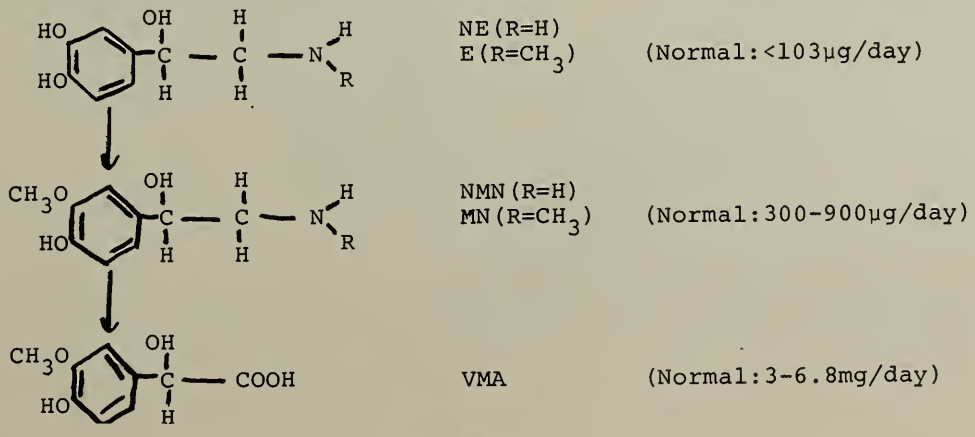


Fig. 1.

Although an occasional patient will have an elevated urinary excretion of VMA or one of the metanephrines instead of total catecholamines, the measurement of any one of these three groups of compounds will usually provide an accurate diagnosis. When total catecholamines are measured, it is important that the patient does not take antihypertensives of the alphamethylilopa configuration, tetracycline antibiotics, and adrenaline-like drugs. When VMA is measured, the patient must be off all coffee, fruits, vanilla, bananas, and asprin. In this patient, total urinary catecholamines were extremely high upon admission to the hospital (5.9 mg.) and fell to about twice normal (274 uq.) shortly before surgery. Over approximately the same time interval, urinary VMA fell from 65 mg. to 19 mg./day. These findings indicate that the tumor was secreting large amounts of catecholamines concomitant with the most severe clinical symptoms.

Once the presence of a pheochromocytoma is diagnosed by biochemical means, an attempt must be made to localize it. Because retroperitoneal air insufflation and arteriography may precipitate a hypertensive episode, these are rarely indicated. Localization is usually adequate with an intravenous pyelogram and nephrotomograms. In this subject, the upper pose of the right kidney did not visualize well with these procedures and suggested the presence of a right-sided tumor. Although measurement of plasma catecholamines from different sites has been used for location in problem cases, procedures for measuring plasma catecholamines are not available in most medical centers.

We have recently been interested in exploring the mechanism of the abnormal glucose tolerance test in patients with pheochromocytoma. According to most series, diabetes is present in at least 50 per cent of cases. It is likely that this figure would be increased if glucose tolerance testing were done in all subjects with this tumor. Until recently, it was accepted that the major reasons for blood glucose elevation in these subjects were the mobilization of liver glycogen by epinephrine, increased glucose production from lactate by the liver, and an inhibition of peripheral glucose uptake by the lipolytic action of the catecholamines. While these mechanisms are contributory, it is likely that a major effect of the catecholamines on glucose tolerance is mediated through an inhibition of insulin release from the pancreas. Studies by Porte et al. have shown that this effect is governed by alpha adrenergic receptors[1,2]. Since phentolamine produces alpha receptor blockade, we reasoned that a phentolamine drip should improve glucose tolerance and insulin secretion in subjects with pheochromocytoma.

Results of this procedure are shown in two subjects below:

	Subject #1		Subject #2	
	K*	Max. Ins. Rise (uU/ml)	K*	Max. Ins. Rise (uU/ml)
I.V. GTT s phentolamine	.43	18	.74	21
I.V. GTT c phentolamine	1.21	50	1.05	58
I.V. GTT post-op.	1.18	60		

*K = rate of glucose disappearance (mg%/min) after I.V. glucose (Normals $>$ 1.0, diabetics $<$ 0.8).

It is apparent in both cases that phentolamine restored the abnormal glucose tolerence and insulin secretion to normal. Patient No. 2 in the table is the case discussed today. While we must study more patients with pheochromocytoma, these early results indicate that the diabetic glucose tolerance frequently seen in this disorder is due to a decrease insulin secretion medicated by alpha adrenergic receptor stimulation by catecholamines.

It is also apparent, therefore, that this patient illustrates the classical clinical and biochemical findings of pheochromocytoma. In addition he has helped provide new information on the abnormalities of carbohydrate metabolism seen in this syndrome.

Dr. Thomas Shields: These patients present a serious anesthetic problem during the removal of the tumor. Dr. Homi is the anesthesiologist in charge of this patient and will comment on the management of the patient during operation.

Dr. John Homi: Anesthetists can come across a pheochromocytoma in two ways: as an emergency or as an elective procedure. The patient may present an abdominal emergency, not usually with intestinal obstruction, because that is indeed rare. They may have abdominal pain and they may be rushed into the operating room with a diagnosis of acute appendicitis, for example, and if the blood pressure is not being moni-

tored carefully, a catastrophe can occur. Indeed, this is how a number of these patients die. One of the patients I managed in Cleveland had a brother who succumbed in this way. He had a cerebral hemorrhage during an appendectomy. It is worthwhile to have Regitine available, although statistically the chances of encountering a tumor in this way are very slight.

There are many ways of preparing the patient medically, and there are advantages and disadvantages to all. In some centers Phenoxybenzamine, an alpha receptor blocking agent, has been used to prepare the patient preoperatively. This smooths out the anesthetic course tremendously, but it has one drawback in my opinion. If multible tumors are present, which occurs in approximately ten per cent, or a small tumor in an unusual site, you may miss a tumor at operation. Another approach to preoperative alpha blockade is to use a Phentolamine (Regitine) drip, the blood pressure being very carefully monitored at all times. A partial block of the beta receptor system with Propanalol (Inderal) can be used in cases where tachycardia or arrhythmias are of concern.

As far as premedication is concerned, I think the patient should be premedicated rather heavily, because anybody who is having an abnormal operation for a rare disease is apprehensive and will secrete catecholamines. Any sort of stimulation of the patient, such as the introduction of tubes preoperatively, adds to the preoperative stress. The induction of anesthesia should be started with a small needle. You should not have to do cut-downs or insert large intravenous catheters into the patient. These are very unpleasant and may be dangerous. A rather slow careful induction of anesthesia, taking frequent pressure measurements, is needed. I think there should be two anesthetists on the case, or two people concerned with anesthesia in the operating room, one of whom does nothing but



Fig. 2. *Pheochromocytoma of right adrenal adjacent to lateral border of the inferior vena cava and the superior edge of the right renal vein.*

watch the pressure at this stage, using either a standard blood pressure cuff or, preferably, an oscillotonometer. Having got the patient intubated without bucking or straining (and this is very important because putting an endotracheal tube into the trachea can be strong stimulus and may trigger a severe bout of hypertension or arrhythmia in these patients), steps to set up suitable monitoring equipment may now be taken. At this time a central venous pressure catheter is inserted as well as some form of intra-arterial pressure monitor. (The one described by Dr. Hale in the Cleveland Clinic Quarterly has proven very satisfactory in my hands.) The accuracy is not as important as the record of change; what you want to know is if the blood pressure is going up or if it is coming down. The pressure monitor must be inserted when the patient is at the proper depth of anesthesia, and before the abdominal preparation starts stimulating the patient. These points are most important because these patients tend to have a fluctuating blood volume as well as a fluctuant blood pressure. We wish to insure that neither hypoxic nor hypercarbic stimulation of catecholamine output is present. The venous pressure, blood pressure, pulse rate, and electrocardiogram are now on display. This enables the anesthesiologist to replace fluid and blood rationally, or to give alpha or beta blocking drugs as indicated.

I would like to point out that unfortunately each case is different. Some have predominantly noradrenalin excretion, some may secrete a lot of adrenalin, a few will secrete very little of either. Thus, some of these tumors give very little trouble during anesthesia, general anesthesia alone being enough to lower their blood pressure. Others can cause cardiac arrhythmias, spiking blood pressures, etc. However, when the proper monitors are used and the appropriate drugs are available, one can usually handle these exigencies. I think the danger with these cases is to underestimate them. When you have only an ordinary blood pressure cuff and do not have an estimate of venous pressure, you can sometimes misinterpret the blood pressure or other changes. Either excessive or inadequate transfusion can result. Similarly, important arrhythmias can go undetected without suitable recording devices.

The choice of what anesthetic agent to use, which is stressed in some of the literature, is not nearly so important as you might think, because actually as long as the patient is at an adequate depth of anesthesia, and without hypercapnia, acidosis, or hypoxia, the various drugs we now have on hand can modify the catecholamine secretion problem. Needless to say, however, agents which are known to significantly sensitize the myocardium to catecholamines such as cyclopropane or trichlorethylene are best avoided. N_20 and 0_2, Halothane, Methoxyflurane and ether have all been used successfully in these patients.

Personally, in the case of small tumors of uncertain situation with little catecholamine secretion I prefer to use an agent to lower the blood pressure by a direct action on the smooth muscle of the vessels. Sodium nitraprusside is the most useful agent of this type. To raise the blood pressure a vasoconstrictor (which is not related to catecholamines, but has a direct action on vessels, namely, angiotensin) is useful. Another non-specific drug, namely Lidocaine (Xylocaine), is effective for controlling ventricular arrhythmias and is widely used in anesthesia. In the case of tumors of known situation which are known to be affecting the myocardium and blood pressure severely, I think there is a place for using alpha and beta blocking drugs both preoperatively and intraoperatively. Postoperatively, replacement of blood and fluid as dictated by changes in central venous pressure, pulse rate, and blood pressure will often render vasopressor therapy unnecessary.

To sum up, it is perfectly possible to manage these cases with many different combinations of drugs. What I think is important in anesthetic management is proper preoperative preparation, skillful induction and maintenance of anesthesia together with setting up proper monitoring systems as I described and thereby keeping full control of the situation during the operative and sometimes critical postoperative period.

Dr. Shields: Dr. Conn, will you comment on the surgical approach to pheochromocytoma?

Dr. Julius Conn: Since 99 per cent of pheochromocytomas will be found in the abdominal cavity, arteriographic studies add very little considering the risk that

they add. From five to ten per cent of them will be multiple, so both adrenal glands, periaortic areas, and anywhere chromaffin tissues are present must be carefully explored. We prefer to explore these patients utilizing bilateral transverse upper abdominal incision, which gives access to both adrenal areas and will give good exposure of the entire retroperitoneal area including the pelvis. I favor exploring the left adrenal using the approach that Brady and Flandreau described in 1958, rather than reflecting the spleen and the colon. An incision is made in the base of the medocolon to the left of the inferior mesenteric vein. This does away with the extensive dissection in the left upper quadrant and still gives good exposure of the left adrenal.

Good preoperative preparation and anesthetic management turns this from a very risky, very difficult operation into just a difficult operation.

The patient's abdomen was explored through a bilateral transverse upper abdominal incision. There was a vascular, firm, 4x6x8 cm. mass in the area of the right adrenal. The mass extended along the superior border of the right renal vein and the lateral border of the inferior vena cava (Fig. 2). There was a prominent thrill felt over the inferior vena cava adjacent to the tumor. As the veins draining the tumor were individually ligated, the thrill diminished in intensity and then disappeared. Careful exploration of the left adrenal, the periaortic region, and the pelvis was negative for an additional pheochromocytoma.

The pheochromocytoma weighed 82 gms. and was cystic in one area (Fig. 3). The cyst contained 12 cc. of bloody fluid which was assayed for catecholamine activity.

The postoperative course was uneventful with the patient ready for discharge on the tenth postoperative day. His blood pressure was 120/80 at the time of his discharge from the surgical service.

References

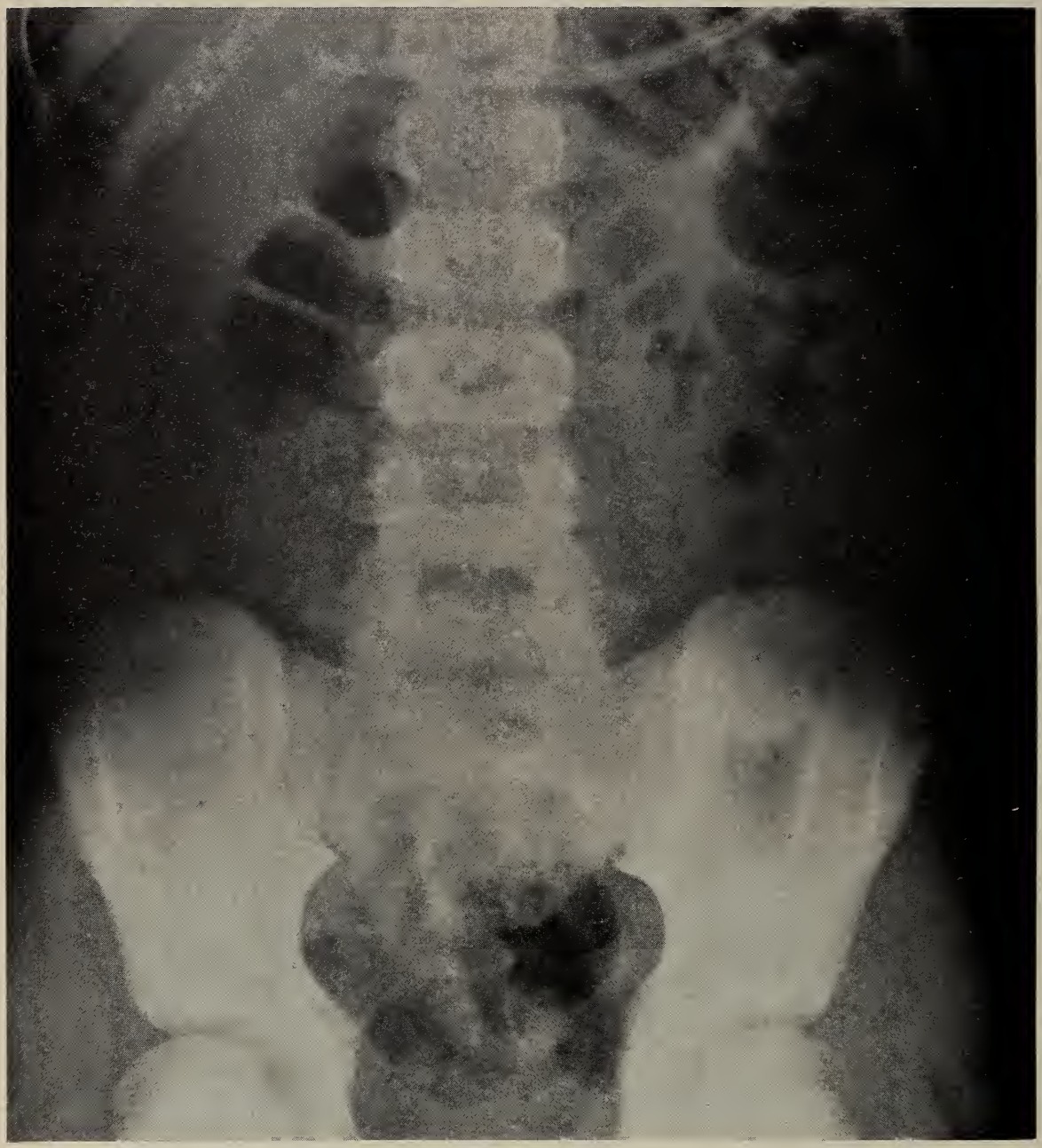
1. Porte, D., Jr, Graber, A.L., Kuzuya, T., and Williams, R.H.: "The Effect of Epinephrine on Immunoreactive Insulin Levels in Man." J. Clin. Invest. 45:228, 1966.
2. Porte, D., Jr.: "A Receptor Mechanism for the Inhibition of Insulin Release by Epinephrine in Man." J. Clin. Invest. 46:86, 1967.



Fig. 3. *Bisected pheochromocytoma showing large cystic area.*

THE VIEW BOX

By Leon Love, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School



This ten year old boy entered with a chief complaint of vomiting of one day's duration and pain which was generalized throughout the abdomen. Physical examination revealed diffuse tenderness throughout the abdomen. A white blood count was 6,500.

What's your diagnosis?

1) Gastroenteritis
2) Acute appendicitis
3) Intussusception
4) Gallstone

(Answer on page 684)

Medical Progress

Automotive Injury and the Practicing Physician

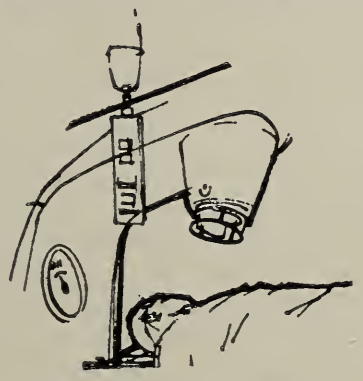
By Eugene F. Diamond, M.D./Chicago and
Seymour Charles, M.D./Newark, N.J.

Automobile injuries, an unfortunate by-product of man's technology, constitute an ever-increasing environmental epidemic which has already reached staggering proportions. Auto accidents now cause 53,000 deaths and over 4,000,000 injuries annually in the United States to rank only behind cancer and cardiovascular disease as a cause of death in our country. Automotive injuries are the number one cause of death for those between 15 and 24 years of age and far outstrip Vietnam and all wars as a killer of youth. Before 1980, one out of every five Americans will have been killed or injured in an auto accident and half of us will be involved in an injury-producing collision in our lifetime.

If drastic preventive measures are not soon undertaken the next ten years will see the number of deaths rise to 100,000 annually and the cost of human and property damage will increase from the current 8 billion to 15 billion dollars annually. The magnitude of the medical problem is illustrated in Table I.

Until the recent past, physicians have concentrated their clinical attention on medical disabilities which compound error and compromise driving expertise. Visual defects, alcoholism, convulsive disorders, mental illness, and other chronic illnesses have been considered to be at least relative impediments to driver licensure but meth-

Medical Progress



Harvey Kravitz, M.D.
Medical Progress Editor

Table I
ESTIMATES OF THE CURRENT IMPACT OF MOVING MOTOR VEHICLE INJURIES ON MEDICAL RESOURCES

HOSPITAL CARE

Annual number of persons hospitalized	502,000
Annual number of days of care	8,534,000
Average length of stay per person hospitalized	17 days
Number of hospital beds required	23,000

PHYSICIANS' SERVICES

In-hospital physicians' visits	8,534,000
Out-of-hospital physicians' visits	5,606,000
TOTAL physicians' visits	14,140,000

MEDICAL ATTENTION BECAUSE OF MOVING MOTOR VEHICLE INJURIES (per year)

Hospitalized persons	502,000
Non-hospitalized persons	2,803,000
TOTAL persons receiving medical care	3,305,000

COSTS OF MEDICAL SERVICES (per year)

Hospital expenditures	$354,844,000
Physicians' services	79,608,000
Other medical services and supplies	280,920,000
TOTAL costs of medical services	$715,372,000

ods of identifying and controlling medical disabilities prior to licensure have been largely ineffectual despite physician interest and participation.

A great burden of responsibility for medical and surgical care for the accident victims has fallen upon the medical profession but the profession has yet to apply its preventive medicine skills meaningfully to this huge epidemic. In these days of overcrowded and understaffed hospitals, it is not difficult to visualize the potential of such a preventive program in reducing the frequency and severity of injuries.

American safety philosophy has traditionally emphasized the human error in accident causation with final assignment of responsibility to the "nut behind the wheel." Various exhaustive public campaigns have been attempted to influence driver behavior with no obvious lowering of accident statistics. Recently various authors[1,2] have developed an epidemiological approach to the control of automobile accidents, and as physicians we are naturally oriented to this approach. The host is our patient in his capacity as driver, passenger, or pedestrian. The causative agent of the bodily injury is the automobile.

Two Collisions in Every Crash

In every crash, there are two separate collisions. The first is the impact of the vehicle itself with another car or obstruction. In the second collision the driver or the passengers, continuing in the same direction of travel as the vehicle, must strike some object of the interior or exterior to interrupt that course of travel. It is this second collision, a fraction of a second after the first impact which is responsible for bodily injury. As studies are directed to the forces and factors involved in the collision of the passenger with the internal vehicle structure or exterior, specific patterns of injury become apparent. These patterns of injury repeat themselves with such frequency that methods of prevention become evident.

Just as in the aircraft, the forces transmitted to the occupants of the automobile are determined by: (1) their attenuation and absorption by structures intervening between the occupant and the point of collision contact; (2) distance and direction of displacement of the occupant; (3) area configuration and resistance of objects against which the occupant is decelerated; (4) attenuation and absorption of forces by the body of the occupant; (5) rate of application of the forces; (6) frequency characteristics; (7) duration.

Investigations Into Crashes

Two early pioneers in the initiation of studies on the correlation between the forces of deceleration and the tolerance of the human being were Mr. Hugh DeHaven, founder of the Cornell Automotive Crash Injury Research Project, and Col. John Stapp of the United States Air Force.

Mr. DeHaven first became interested in the mechanics of injury and safety design when he escaped serious injury while in the Royal Air Force during World War I. His side of the cockpit had remained intact and he survived, while his associates were killed in the crushed contra-lateral side of the plane. As he began his studies, he noted that "many of the traumatic results of both air and auto accident could be avoided. Structures and objects by placement and design created an inevitable expectation of injury in even minor accidents."

DeHaven[3] established that the apparent miraculous survival in the instances of freefall indicated that the human body under the conditions of extreme force was capable of unexpectedly large tolerances. He maintained that "the person who escapes in a high speed crash, owes his life to some decelerative interval and to a favorable distribution of pressure." The basis for the modern concept of occupant and pedestrian protection is that structural provisions to reduce impact and distribute pressure can enhance survival and modify injury within wide limits.

About twenty years ago, Col. Stapp[4] realized that for all his efforts to improve the safety of pilot and passengers in air



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Seymour Charles, M.D., is from Newark, New Jersey. He is National Chairman of the Physicians for Automotive Safety.

flight, personnel losses were larger from automobile accidents. He recognized the similarity of crash forces. "Must exposure to mechanical force invariably result in injury or death? How much mechanical force can a human body withstand and survive with no permanent ill effects? What protective measures can be employed to insure survival up to a limit of failure of the human body?"

Using himself as a subject, Dr. Stapp undertook a series of courageous experiments, propelling himself at over 600 miles per hour and then coming to a sudden stop. He personally recorded the limits of tolerance of the human body to the force of deceleration. He became convinced that the human could absorb such forces that a whole car could be designed from top to bottom, from side to side, from bumper to bumper to crash safely and allow the occupants to walk away with minimal injuries.

The Safer Automobile

Substantial evidence has now been accumulated to show how Stapp and DeHaven's pioneer research can be brought to the drawing board in the design of a safer automobile:

1. Build the package, that is the car body, strong enough so that it will not collapse, crushing the contents of the car (the occupants).
2. Construct the door, including door locks, so that doors will stay closed to prevent the occupants from being thrown out of the car against some solid object. Doors should open easily after a crash so that the occupants can get out.
3. Restrain the occupants so that they will decelerate with the car instead of hitting the interior of the car, thus reducing the stopping force.
4. Design the interior of the car so that when the occupants are thrown forward they will come in contact with larger and energy-absorbing areas, thus reducing the stopping force.

These engineering principles can be effectively implemented because each accident is not just another isolated tragedy of human error. Non-industry research at Harvard,[5] Cornell,[6] UCLA,[7] and Michigan[8] Universities shows specific patterns of bodily injury.

Injury Causing Facets

There is repetition of injury causation in hundreds of automobile accidents every day where the accident causation is far less uniform. Specific interior and structural design features have clear relationship in frequency and type of injury in study after study. The steering assembly, the windshield, instrument panel, upper part of the front seat back rest, door structures, lower part of the front seat back rest, corner post, headers, sun visors and hardware are leading sites of injury-producing impact.

In both the Cornell and Michigan studies, the steering assembly accounted for about 20% of the serious injuries, usually to the driver as he is thrown forward, crushed or impaled. Restraining devices have limited protection for the driver as the steering assembly invades the occupant area in ramrod effect.

The instrument panel with its assortment of protrusive knobs accounted for 12% of the deaths in the Huelke-Gikas[8] investigations of 170 automobile fatalities in Washtenaw County, Mich. Even the recently fashionable superficial padding of these panels has not corrected underlying edges which, as Mr. DeHaven observed years ago, act as a steel beam or anvil inflicting head and face injuries.

The Cornell[9] studies show over 11% of the injuries are caused by the windshield, meaning that at least 200,000 of our patients are disabled or disfigured annually, often with long, expensive convalescenses.

Although the steering assembly, instrument panel and windshield—in that order—were the most dangerous, the most serious cause of injury to the occupant was ejection from the car itself. Cornell data showed that ejection from the vehicle accounted for about 25% of serious and fatal injuries. The risk of fatal injury was increased fivefold if the occupant was thrown from the car. Ejection occurs when the doors pop open after crashes and the occupants are hurled free of the vehicle.

Ejection Causes Most Serious Injuries

In a Ford Motor Company survey in some 22 states, the reduction in injury and death to those wearing seat belts was significant, in that those wearing seat belts incurred 66% fewer injuries and 80% fewer deaths. In the Huelke-Gikas studies of the

University of Michigan, 40% of the deaths were preventable had restraining devices been used. Even if the effectiveness of seat belts at high speeds is questioned, studies still show a large measure of protection can be afforded regardless of the speed of impact.

The tragedy of ejection is that even a minor accident can produce a fatality as the person is likely to be run over by another car or seriously strike some fixed object. Cornell[10] studies also showed that roll-overs, which occur in one out of every five rural accidents, are especially lethal and not infrequently result in the ejected passengers being pinned beneath the cars.

For the past 20 years, seat belts have been the most effective single available device to reduce the severity of injury in the second collision. Properly designed, tested and installed restraining devices for the driver and his passengers, regardless of the individual positions in the car, for example, do:

1. Minimize contact of the vital parts of the body from injurious impact with the interior of the car.
2. Secure the position of the driver and occupants in their properly seated positions in order to prevent loss of control of the car.
3. Prevent ejection of the driver and passengers from the vehicle and injury producing contact with outside objects, crushing by the vehicle, or crushing by other vehicles.

Although these facts have been known for two decades, the simple lap belt has yet to be installed in more than 1/3 of the American cars; the incidence of utilization is even less. It is already evident that the shoulder strap harness arrangement, preferably in combination with a lap belt in a three point insertion, would be much more effective in preventing severe injuries for the front seat passengers. Harness type restraints are even more important for infants and children, as they habitually romp and jump about in the fast moving car and not only are a perilous distraction to the driver but put themselves in constant jeopardy with a sudden collision.

Other studies implicate overall construction and weight of automobiles.[11] Accidents were studied involving cars of various weights, classified as follows: (1) 771 small foreign cars of under 2,000 pounds; (2) 1,085 foreign and American cars of between 2,000 and 3,000 pounds; (3) 10,979 American standard size autos of more than 3,000 pounds.

In class 1 there were 20% more severe accidents and 50% more fatal accidents than in class 3. Class 2 with 75% American and 25% foreign cars fared only slightly better than the light weights. The major factor in the poor record of the small cars was a 63% higher ejection rate than class 3, and 25% higher ejection than class 2. Furthermore, the lightest cars were more often involved in roll-over type accidents: 47.4% for the small cars, 26.9% for the medium-size cars and 20.6% for the heavy cars.

Release of Research Data

No other field of medicine has such a restriction of publication of research and investigation. The studies of human tolerances of forces of deceleration, the patterns of injury determined in retrospective and planned crash studies, and the established means of occupant and pedestrian protection are not presented and discussed in the regular medical journals of this country. U.S. government subsidies have paid for most of the research done by the superb organization of the Cornell Crash Injury Research project. The public release of much of this valuable investigation is controlled not by the Public Health Service but by the Automobile Industry.[12] The important research reported at the annual Stapp Crash Conferences and meetings of the American Association of Automotive Medicine is seldom circulated in the popular lay press although the most intricate details of virology, cancer therapy and genetic research are regularly presented. When the medical profession understands the available means of injury prevention, there will be a sharpening of clinical correlation in practice and reporting of new experiences. The present grim acceptance of accident pathology from the automobile can be replaced with inquisitive evaluation of each patient's bodily injury and disability in terms of how this experience might be applied to prevention. This is the same rationale which permeates all other aspects of medical practice.

One of the most serious and chronic bodily injuries, especially to the front seat passenger and driver, is that called the whip-

lash. Here, the forces of deceleration throw the neck and head into extreme extension to produce severe hemorrhage and tearing of the musulo-skeletal structures in the posterior neck. A properly positioned headrest would prevent this injury or reduce its severity.

A gamut of design deficiencies show lack of attention to problems of driver and pedestrian visibility. Automobiles can and do become invisible day and night with obvious implications in accident causation. Visual obstructions are caused by windshield glare and distortions, cornerposts, rearview mirrors, rear corner blind spots, and glare off of the vehicle surface. Vehicle signal systems are inadequate and hazardous. Corection of most visual defects involves application of known technological means.[13]

Representative Kenneth A. Roberts, former chairman of the Subcommittee on Health and Safety of the House Interstate Commerce Committee spent more than ten years studying the problem of highway safety. In August of 1964 the Roberts' Bill was passed which requires the Congress to establish safety standards for automobiles to make it illegal for any car to be shipped in interstate commerce that does not meet these standards. In effect, the legislation requires the General Services Administration to establish safety standards for cars which the government will purchase. Although the government purchases less than 60,000 vehicles per year, it was believed that, by using the level of federal supply standards, the automobile industry might be encouraged to extend the same safety features required in government cars to those sold to the general public.

With the recognition of automotive injury and death in an epidemiological context as preventable disorders, at least in part, the medical profession can assume a more meaningful role in their control. The physician can join with automotive engineers, highway safety technicians and other members of an aroused and anxious citizenry. Hopefully, such a conjoint effort might reverse the trend of this runaway epidemic of trauma and death.

Summary

1. Automotive injury and death constitute a huge public health problem which is on the increase.
2. Epidemiological approaches to this problem would seem to offer the chief hope of success in effecting reduction.
3. "Second collision" type injuries could be favorably influenced by improved automobile exterior and interior design.
4. Passenger restraint systems are also important in reducing various types of injury including those due to ejection.
5. Greater professional and public awareness of the problem and its preventable aspects are needed.

References

1. Severy, D. M., Mathewson, J. H., Siegel, A. W.; Automobile Head-On Collisions, Series II SAE Trans. 67:238, 1959.
2. Haddon, W., Klein, D., and Suchman, E. A.; Accident Research, Methods and Approaches, New York, Harper & Row Publishers, Inc. 1965.
3. DeHaven, H.; Mechanical Analysis in Falls of Fifty to One Hundred and Fifty Feet. War Medicine 2:586, 1942.
4. Stapp, J. P.; Human Tolerance to Deceleration; Am. J. Surg. 93:734, 1957.
5. Moseley, A. L.; Research on Fatal Highway Collisions; Boston, Harvard University Press, 1962.
6. Moore, J. D., et al; Child Injuries in Automobile Accidents; New York, Cornell Automotive Injury Research, 1960.
7. Mathewson, J. H., et al; Automobile Head-On Collisions, Series III SAE Reprint 211 D, August 1960.
8. Gikas, P. W. and Huelke, D. F.; How Do They Die?; SAE Publication 1003 A, 1965.
9. Automobile Crash Safety Research; Buffalo, New York: Cornell Aeronautical Laboratory, Inc. 1955.
10. Study of Human Kinematics in a Rolled-Over Automobile; Buffalo, New York: Cornell Aeronautical Laboratory, Inc. 1959.
11. McFarland, R. A., Moore, R. C., and Warren, A. B.; Human Variables in Motor Vehicle Accidents, Review of the Literature; Harvard School of Public Health, Boston 1955.
12. Nader, R.; Unsafe At Any Speed; New York, Grossman 1965.
13. Allen, M. J.; Certain Visual Aspects of the Average Modern American Automobile; J. Amer. Optometry Association 5:380,1962.

Faith may be defined briefly as an illogical belief in the occurence of the improbable.—H. L. Mencken

Tragic Deaths Of The Lincoln Sons

By Emmet F. Pearson, M.D./Springfield

The essential elements of early Greek tragedies rested on an inner triumph in spite of outward defeat. The Lincoln tragedy is quite the opposite, with outward triumphs that have favorably influenced the entire human race but brought complete inner defeat and demise to the Lincoln family itself. The sublime tragedy of the Lincoln family story reaches its full impact when we recall the lamentable early deaths of four of the five Lincoln sons. The final pathos of this true-life drama of a once happy Springfield family comes with the extinction of the family lineage.

Nearly everything that even remotely involved Abraham Lincoln is of great interest around the world. More has been written about Lincoln than any other person who has lived on this planet with the possible exception of Jesus Christ. The personal tragedies of Abe and his wife Mary are known to most, but the terrible anguish caused by the illness and deaths of their sons deserves to be retold.

Abe was a strong young man, but became a self-styled hypochondriac and had several fits of deep depression. He was an indulgent father who suffered greatly with each of his children's illnesses and deaths. Mary was a vivacious, gracious and extraordinarily ambitious young woman. She was forced to watch three of her four sons die and to see her husband murdered. These bombardments of psychic trauma completely broke her. She was committed for a while to a mental hospital and her last years were most unhappy.

The health problem of the Lincoln family encompassed the amazing period of transition in medicine from the backwoods of Kentucky and the rugged frontier town of New Salem, through the rising status of medicine and increasingly well educated doctors in Springfield, on to contact with sophisticated 19th Century medicine in Europe and vigorous young Chicago.

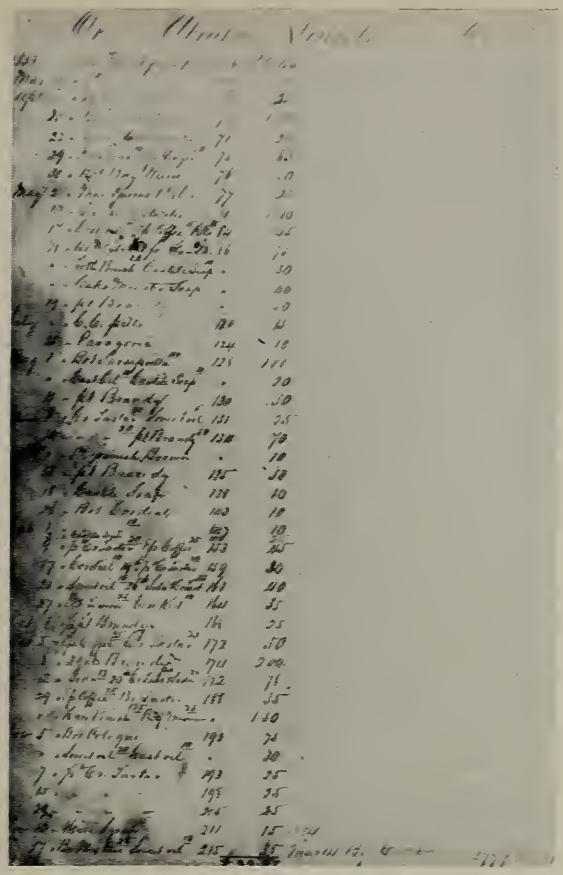


Emmet F. Pearson, M.D., is an internist. He is a graduate of Washington Univ., St. Louis, and served his residence at Barnes Hospital. Dr. Pearson is a member of the ISMS Archives Committee and this article is another in a continuing series commemorating Illinois' Sesquicentennial.

Lincoln's Purchases of Drugs

Lincoln himself had close personal relationships with many doctors of strong personality, and the family, while living in Springfield, had reason to call on several prominent doctors as family physicians. It appears that the most frequent prescriber for the Lincoln family was amateur Abe himself. He made frequent purchases at the Diller Drug Store, the accounts of which have been preserved. (Photograph of ledger page). Among the medicines that Lincoln purchased were castor oil, Calomel, Dr. Jaynes' carminative, Brown's mixture, cough candy, spirits of camphor, glycerine, ipecac, paregoric, Wright's pills, pennyroyal and much brandy. It is reasonably safe to assume that the castor oil and calomel were for the boys.

Of Abe's and Mary's four sons, only Robert reached maturity. Robert's only son, Abraham Lincoln II, died at the age of 16. There were many unknown aspects of the lives, health and deaths of all the Lincoln male heirs. Many letters are extant that pertain to the sicknesses of the boys. News-



A page from the ledger of Diller Drug Store, Springfield, showing purchases by Lincoln in 1853.

paper reports are available, and documents, county records and the research of early historians are sufficient to fill in many details. Some personal communications of the late Dr. Marion Pratt and Dr. Wayne Temple, Springfield historians, are included.

Robert Lincoln, the first child, was born in the Globe Tavern in Springfield exactly nine months after the hectic marriage of his parents. At that time, Dr. Anson G. Henry was probably the family doctor. Dr. Henry had been a student of the great Dr. Daniel Drake of Cincinnati. Mrs. Lincoln wrote that Dr. Henry was her dearest friend. Mrs. A. T. Bledsoe, a friend of Mrs. Lincoln's, whose husband became Assistant-Secretary of War in the Confederacy, later wrote that she was in attendance at the birth of Robert.

Lincoln Sons Described

Robert was an introspective, undemonstrative, shy youth, who had a divergent eye. He appears to have been quite intelligent and graduated easily from Harvard College. When he was fifteen years old, he was bitten by a dog presumed to be mad. His father took him to Terre Haute, Ind., to have a mad stone applied to the wound, to draw out the green poison and prevent hydrophobia. (There will be more about Robert's family, after discussion of his brothers.)

When the next son, Edward Baker (Little Eddie) came along, the Lincolns were becoming prosperous and owned the home on Eighth Street in Springfield. Only a few letters refer to Eddie, who was said to be a "sweet" boy. His death, which occurred in 1850, was perpetually lamented by his parents. In Lincoln's farewell address to his friends in Springfield, he said, "Here I have lived a quarter of a century—and here one child lies buried." Early historians said that Eddie died of diphtheria but that diagnosis seems unlikely. Lincoln himself wrote that the boy was sick fifty-two days and the mortality schedule of the 1850 Federal Census reported that he died from "consumption." One wonders if, indeed, there was tuberculosis in the family. Brother Tad probably died from TB and Willie, the other brother, died from some type of respiratory infection. It seems probable that Robert's son, Abraham II, might have had tuberculous empyema. Eddie's body was removed from an old cemetery many years ago to lie in his father's tomb. Only a few years past, his original tombstone was found lying face down, and the following inscription was noted on it: "Of such is the Kingdom of Heaven." This is a line of a verse which appeared anonymously in a Springfield paper after Eddie's death probably written by Mary Lincoln:

"The angel death was hovering nigh
and the lovely boy was caused to die,
Bright is the home to him now given
for such is the Kingdom of Heaven."

The third son, William Wallace Lincoln, "Willie," was born in 1850, not long after the death of Eddie. He was named after Dr. William Wallace, whose wife, Frances, was a sister of Mary Todd Lincoln. Dr. Wallace was by this time the family doctor. He probably officiated at Willie's birth. Willie was a handsome, precocious, energetic and lovable boy by all accounts. He suffered repeatedly with spells of fever. One very severe spell came on after Lincoln's election to the presidency, before the family moved from Springfield. This episode was diagnosed as scarlet fever and his

younger brother, Tad, was sick at the same time. The occasion of this illness is depicted in the accompanying picture which was made when the sickroom in the Lincoln Home was reenacted, showing the two boys sick in bed. Drs. Henry and Wallace are in attendance, and the distraught parents are looking on.

Willie's Death

About a year after the Lincolns were settled in the White House, Willie contracted a cold while he was riding horseback. Dr. Robert Stone, Professor of Medicine in what is now George Washington University, was the Lincoln family doctor. Willie became progressively worse and died 17 days later. Dr. Stone said his fever was "intermittent and assumed a typhoid character." It would appear to us more probably that he died from pneumonia, and that he had been weakened by preceding, recurrent respiratory infections. Willie's body was temporarily buried in Washington but it accompanied his father's on the funeral train, when the President's body was returned to Springfield in 1865.

Much more has been written about Thomas (Tad) Lincoln than any of the other brothers. Dr. Wallace probably also officiated at his birth in 1853. "Tad's" father said that he had "a head like a tadpole." He had a mild cleft palate and talked with a lisp. He was mischievous, incorrigible and would not study. At age 12, he could not read. Like Willie, he had frequent bouts of fever. He was sick when Willie died in Washington and he was scheduled to accompany his father to Gettysburg on the day of the famous speech, but became ill and could not go. On one occasion, Mary Lincoln wrote a friend, who was going to Chicago where Mr. Lincoln was "politicking," asking the friend to "tell Mr. Lincoln that Tad is sick with high fever and I do not like his symptoms and I will be glad if he will come home."

Mary Lincoln Returns to Chicago

After the President's death, Mary Lincoln was distraught, restless and generally mixed-up. She sailed for Europe in 1867 to place Tad under English and German tutors. He appeared to take more interest in learning then, and once told a reporter that he hoped to study medicine. Tad was sickly most of the time and developed signs of pulmonary tuberculosis while he was in Europe. He and his mother returned to Chicago in 1871. Tad was under the care of several famous Chicago physicians, including Dr. N. S. Davis, one of the founders of the AMA as well as of Northwestern University Medical School. Dr. H. A. Johnson and Dr. Charles Smith also attended Tad. When Tad died in July of 1871, at the age of 18, the official diagnosis was "pleurisy and dropsy of the chest," but there seems little doubt today that he had tuberculosis. "Tad's" death later precipitated a complete nervous breakdown in his mother, causing her to be committed to a private sanitarium, Bellevue Place, at Batavia. She was successfully treated by the kindly Dr. R. J. Patterson, pioneer Illinois psychiatrist.

Robert Lincoln, the oldest son, lived to the ripe age of 83. He was eminently successful as a lawyer in Chicago and as a businessman, becoming president of the Pullman Company. He remained aloof, was considered somewhat eccentric, and is said to have been embarrassed by his father's backwoods background. Although Robert Lincoln had no known major illnesses in Chicago, he had contact with some of the great names in Chicago medicine, such as Billings, Bevan and Murphy.

Robert's Life Recounted

Robert married Mary Harlan, daughter of wealthy Senator Harlan of Iowa. Their eldest daughter, Mary, married Mr. Lincoln's secretary, Charles Isham, and they had one child, Lincoln Isham, who never married, and now lives secluded in retirement in Vermont. The second daughter of Robert Lincoln, Jessie, caused her father great anguish by eloping with a baseball and football player named Warren Beckwith. The Beckwiths had one son, Robert Todd Lincoln Beckwith, who lives quietly in Washington. He married late and has no children. He visited Springfield for the first time in 1965 on an occasion honoring his great grandfather. Observers thought he was not in good health. Mary Lincoln Beckwith, the only other child of Jessie Lincoln, never married and lives a secluded life in Vermont.

One of the most lamentable premature deaths was that of Abraham Lincoln II, called "Jack," son of Robert. Jack was said to have been a truly gifted, precocious

child, the reincarnation of his grandfather and namesake. While his father was serving as Ambassador to the Court of St. James in London, Jack was sent to Versailles in order to study French and to prepare for Harvard. He became ill with fever in France and a large carbuncle developed in his right armpit. This tumor was incised and drained by two French doctors named Peau and Villon. The abscess would not heal, and the boy became progressively worse. He was moved across the English Channel by special boat to London. There he was attended by several famous London doctors, including Sir James Paget. Dr. Webster Jones of Chicago, who was in London, was called in consultation. The boy gradually became cachectic and a Dr. J. MacLagan said the cause of death was "carbuncle with pleurisy." At this late date, the course of the disease sounds to us now like tubercular empyema. Jack's body was taken to Springfield for burial, but on his father's request, it was later removed to Arlington Cemetery, where it rests near those of his father and mother. How much this extraordinary person might have contributed to the welfare of the world if his life might have been saved by drugs like Penicillin and Streptomycin is anyone's conjecture; the same may be said of his Uncle Willie.

After Jack's death, Robert Lincoln was despondent much of the time, and a manservant was constantly at his side to prevent a possible suicide. In 1909, on the 100th anniversary of the birth of his father, Robert came to Springfield in his special Pullman car. I was told by my uncle, Mr. William Pavey, who was on the Greeting Committee, that they could not get Mr. Lincoln off his car and that the committee thought that he was not sober. He died at age 83 at his summer home in New Hampshire, of a cerebral hemorrhage.

Aristotle said, in effect, that the reason why people enjoy tragedies is that the painful actions and problems of others, which excite pity and fear in the observer, may purge him of these emotions: Perhaps the great popularity of the Lincoln family story may in part be explained by this Aristotelian hypothesis. Certainly no family has suffered and died more sadly than did the Lincolns, and none seem less to have deserved such a fate. Perhaps grievance for the Lincolns may challenge us all to increased sympathy, ruth and compassion.



Reenactment of sickbed scene in the Lincoln Home showing Willy and Tad in bed with severe scarlet fever. Doctor Anson G. Henry and Doctor William Wallace are in attendance.



FELDSHERISM

Many groups hope to solve the "doctor shortage" by developing a semi-professional body of medium-grade medical workers (MMW) with a role between that of the current physician and nurse. Before doing so, they should investigate the Russian feldsher, often described as a "second-class doctor for peasants." He (or she, since 90 per cent are women) is a physician's assistant, taking over tasks that are delegated to him.

History is a wonderful teacher. Peter the Great introduced semi-professional medical workers into the Russian armies in the seventeenth century. According to Dr. Victor W. Sidel[1,2], the Tsar lacked trained physicians for his large army. They were called feldshers and the group was active for two centuries until replaced by better trained medics.

On retirement, many became civilian feldshers; they practiced mainly in the country caring for the peasant population. Local Russian governments started special schools for the group, and by 1913 there were 30,000 feldshers who outnumbered regular physicians two to one.

During revolutions the feldshers were used politically to make the regular physicians toe the mark. After the revolutions, the Soviets decided to abandon feldsherism because it was considered second-class rural medicine. A long battle ensued and the struggle ended by making them a part of the medium-grade medical workers (MMW) that includes midwives, nurses, pharmacists, and dental and X-ray technicians. Approximately 30,000 feldshers graduate each year from a Technicum, a secondary vocational school, rather than an institute or university. The majority are women. They practice mainly in rural areas and give emergency medical treatment and first aid. Soviet writers describe them as doctor's helpers. They are part of the medical team.

Many physicians admit that they could not practice complicated Soviet medicine without the help of middle medical workers. This is true, especially of the 86,000 feldsher-midwife stations that dot the countryside and mountainous areas. At the present time, there are 538 MMW schools with an enrollment of 250,000 students. Career choices must be made at the very beginning because the student is trained as a feldsher, midwife, sanitarian-feldsher, pharmacist, or a laboratory-feldsher. All technical subjects are taught by physicians. Professional teachers supply theoretical or general education subjects (68 per cent). Students having unsatisfactory grades may repeat the courses once, and if the performance is still unsatisfactory, are dropped. Those in the top 5 per cent of the classes are permitted to take entrance examinations for the medical institutes. Other graduates may apply for evening medical school after two years, provided they work as feldshers during the day. Still others can apply after three years of obligatory service to become full-time medical students.

Do we want this? There are wide cultural differences between our heritage and that of the Russians. The feldsher developed in

Russia when communications were primitive. Originally he supplied the medical needs of a rural community. Today Soviet policy-makers have him as part of the medical team guided by a physician. In other words, feldsherism is a lesson in comprehensive health care.

On the other hand, American medicine has fought against the second-class doctor for more than a century. The feldsher is just that, except that he is trained by physicians. In this respect, he is an improvement over the American chiropracter, naturopath, or Christian Science practitioner. We firmly believe that all medical treatment should be given by licensed physicians of the highest caliber. Conversely, if helpers are needed, we should take the initiative in supplying the demand.

T. R. Van Dellen, M.D.

References

1. Feldshers and "Feldsherism." Victor W. Sidel, *The New England Jl. of Med.,* (Apr. 25) 1968, *278*:17, pgs. 934-939.
2. Ibid. The New England Jl. of Medicine (May 2) 1968, *278*:18, pgs. 987-992

CHILDREN'S ACCIDENTS AND MEDICAL EDUCATION

An important paper was reported at the recent meetings of the National Childhood Injury Symposium in June, 1968. Dr. Roger Meyer, the founder of this symposium and a recognized authority on children's accidents, reported on the results of a survey of the teaching of children's accidents in the pediatric departments of seventy-seven medical schools in this country.[1] The survey clearly showed that the teaching about accidents in childhood was grossly inadequate. This study confirms a previous study by Top in 1960, who reported that departments of preventive medicine of a number of medical schools gave less than three hours of instruction per school year.[2]

Dr. Meyer contrasted the lack of instruction in our medical schools with the staggering morbidity and mortality due to accidents. He stated that one out of three children in the course of a year will require medical attention for injuries. Trauma continues to be the leading cause of death, taking a larger toll than the next four diseases combined from the ages of one to twenty-one years.

Why is the medical student given so little exposure to such an important subject? The apparent answer is that medical education has not been modified sufficiently to meet the pressing national problem of accident prevention in children. The lack of qualified specialists in accident prevention to teach the subject is also a serious handicap to progress in this area.

Featured in the medical progress section of this issue is an excellent paper on automobile accident study and injury prevention by Eugene Diamond, M.D., and Seymour Charles, M.D., recognized authorities in this field. It is hoped that more physicians will become actively interested in research in the prevention of the huge number of accidents which afflict almost all of us. Your attention is also directed to Dr. Pachman's article on children and smoking.

Harvey Kravitz, M.D.

References

1. Meyer, R. J., Childhood Injury and Pediatric Education: A Critique. Proceeding, National Childhood Injury Symposium, June 30, 1968, Charlottesville, Virginia.
2. Top, F. H.: A Survey of the Teaching of Accident Prevention in Departments of Preventive Medicine, J. Med. Ed. 35: 1152-53, 1960.

FILM REVIEW

"Seven for Susie," a film available from the National Easter Seal Society, is the dramatic and true story of a little girl who seems hopelessly crippled. The film is an attempt to overcome the lack of knowledge about professional career opportunities in rehabilitation open to young people. It depicts a child's struggle to overcome her problems with the help of seven dedicated rehabilitation professionals including a physical therapist, occupational therapist, social worker, speech pathologist, psychologist, recreation specialist and special educational teacher. Aimed primarily at junior and senior high school and college students, the 13½ minute 16mm. color sound film is available through state Easter Seal Societies or may be purchased at $50.00 from Careers in Rehabilitation, National Easter Seal Society, 2023 W. Ogden Ave., Chicago, Ill. 60612.



THE DOCTOR'S LIBRARY

DIAGNOSTIC PROCEDURES IN GASTROENTEROLOGY, Edited by Charles H. Brown, M.D., 438 pages, illustrated, C. V. Mosby Co., St. Louis. 1967, $19.50.

The present volume began as a manual for the Fellows in Gastroenterology at the Cleveland Clinic to describe the various diagnostic procedures along with their indications and contraindications. The purpose of these procedures is to enhance the diagnostic ability of the clinician. Many of the sections are followed by nurses' notes outlining the equipment necessary for the procedure, the preparation and post-procedural routines.

Especially valuable is the introductory section on general topics, wherein the diagnostic procedures as a group are discussed in relationship to the other aspects of diagnosis. The procedures, including gastric analysis, endoscopy, liver and small bowel biopsy, specialized roentgen techniques and pancreatic scanning, are discussed. The sections include the Esophagus and Stomach, the Pancreas, Intestinal Absorption, the Liver, the Rectum and Colon, Miscellaneous Procedures and Specialized Treatment. These sections are followed by two supplements:—Special Instructions to Patients and Diets.

The approach is a highly personal one, reflecting the experience of the Cleveland Clinic. Practical aspects are emphasized. The book collects much information not previously available in one place. As such, it should be a useful reference work for interested physicians and paramedical personnel.

E. Clinton Texter, Jr., M.D.

CLINICAL PATHOLOGY/INTERPRETATION AND APPLICATION, Benjamin B. Wells, M.D., Ph.D. and James A. Halsted, M.D., W. B. Saunders Company, Philadelphia, 1967, 708 pp.

This book attempts to narrow the gap between research knowledge derived from basic science and the everyday practice of medicine. It describes laboratory medicine from the point of view of the practicing pathologist, and is organized around clinical situations in which laboratory tests yield valuable information.

After an introductory chapter in which statistical considerations are reviewed, the book is divided into sections, including: metabolic disorders, diseases of the gastrointestinal tract, kidney, blood, heart and lungs, and infectious diseases. The last chapter gives the details of certain laboratory procedures selected on the basis of physician involvement, including procedures which the physician performs himself or which require physican participation.

As in previous editions, this book fulfills its purpose and should maintain its well-earned place in the library of medical student or practitioner.

Joseph C. Sherrick, M.D.

There is now a single, strong, national organization working to bring a better life to two million Americans with epilepsy. Epilepsy Foundation of America—a union of The Epilepsy Foundation and Epilepsy Association of America—offers the great promise of hope to all these forgotten people. To find out what you can do to help, write to Epilepsy Foundation of America, Washington, D.C. 20005.

MEMBERSHIP SURVEY RESULTS

What You Said
What ISMS Is Doing

Part I: LEGISLATIVE and LEGAL Issues

TURN THESE PAGES to find your collective viewpoint on liberalizing the Illinois abortion law . . . reducing LSD and marijuana penalties . . . and three other key issues.

In this and the next two issues of the *Illinois Medical Journal,* we will tell you what you told us in the membership survey last August.

And we shall state—in these issues—what actions ISMS intends to take in response to your opinions. Indeed, a primary aim of the survey was to achieve a greater harmony between your wishes and society endeavor.

Our reason for dividing the report into three extensive installments is that never before had ISMS conducted a membership survey of such breadth, depth—and significance.

This first installment is devoted to issues that are essentially Legislative and Legal. It thus can serve as a curtain-raiser for ISMS activity in the General Assembly session that convenes two months hence. As these pages show, your responses already are influencing our legislative positions.

In the December issue, we shall report on the Socio-Economic questions. Your responses on these will be guiding us in many areas—including steps to relieve the physician shortage, care of the medically deprived and dealings with state welfare agencies.

In January, we'll cover issues involving Professional Practice. Your reactions on these will be guiding us on such matters as midweek off-day schedules . . . a 7-day hospital week . . . health-care costs . . . and our relations with hospitals and paramedical groups.

In addition to giving the general results on all major questions, we are including responses by category—such as age, area and field of practice—wherever they seem meaningful.

While elated by the over 3,000 replies you sent us in a hot month of over-work or vacations, we realize that any survey—regardless how carefully prepared or well received—has certain limitations.

We are aware that on such complex topics, our questions—and your checkmarks—could not always convey the full message. Indeed, some of you volunteered comments alongside your answers, and for these we are especially grateful.

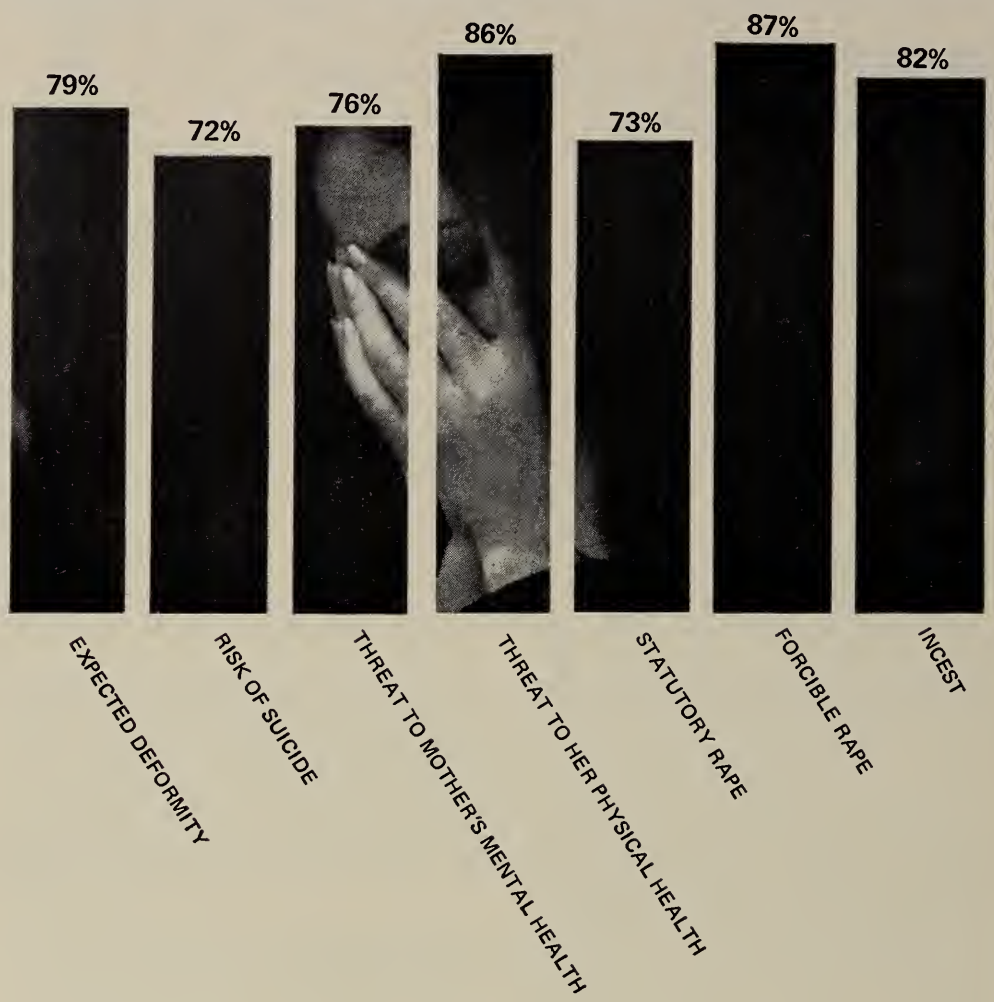
Such qualifications aside, we believe the survey—and your response—represents a valuable exchange of ideas between the officers and you members . . . a splendid act of cooperation for the good of us all.

Matthew B. Eisele, M.D.

MATTHEW B. EISELE, M.D.
CHAIRMAN, COMMITTEE
ON PUBLIC RELATIONS

LEGALIZED THERAPEUTIC ABORTION

ILLINOIS MD's FAVOR MODERNIZED LAW IN THESE INSTANCES:



QUESTION AND GENERAL RESPONSE:

The ISMS House of Delegates last May left open the question of liberalizing the Illinois abortion law. Do you favor an amendment that would legalize therapeutic abortion in well-substantiated cases of:

	% of M.D.s IN FAVOR:
a. Expected deformity of the fetus?	79%
b. Risk of suicide by the mother?	72%
c. Severe risk to mother's mental health?	76%
d. Grave threats to her physical health?	86%
e. Forcible rape?	87%
f. Statutory rape?	73%
g. Incest?	82%

While a majority favored legalized abortion in all the circumstances specified above, only 45 per cent said "yes" to the question: "Would you favor an amendment setting no conditions, and leaving the abortion decision to the physician's discretion?"

BREAKDOWN:

Although the different age groups were in fundamental agreement, the percentage of favorable responses generally was higher among older physicians.

In each membership category, here were the lowest and highest percentages of favorable answers on the seven types of therapeutic abortions:

By *age:*		
	Under 40	63% on "f"–80% on "d"
	40-55	70% on "b"–86% on "e"
	Over 55	77% on "b"–92% on "e"
By *area:*		
	Chicago Medical Soc.	75% on "b"–89% on "e"
	Downstate	67% on "f"–86% on "d"
By *field of practice:*		
	General practitioners	70% on "b"–88% on "e"
	Specialists	72% on "b"–87% on "e"

BACKGROUND:

Illinois—like most other states—outlaws abortion except to preserve the mother's life. In all other circumstances it is a felony subject to one- to ten-years imprisonment.

The ISMS House of Delegates—at its last two annual meetings—debated proposals to modernize the Illinois law, but reached no decision.

At this year's meeting it referred the issues back to the Committee on Maternal Welfare—for development of any information that would warrant a changed position. The committee has favored modifying the law.

The ISMS supported a General Assembly bill to create a special study commission on the abortion issue, but the bill was vetoed by former Governor Otto Kerner.

The AMA in June, 1967, held that certain types of therapeutic abortions were consistent with medical ethics. A recent Gallup Poll showed that 77 per cent of the public —including 63 percent of the Catholic population—favored such abortions. Colorado, Georgia, Maryland, North Carolina, Mississippi—and last November, California—have relaxed their laws.

ACTION TO BE TAKEN:

The Board of Trustees, at its October 5 meeting, referred the survey results to the Maternal Welfare and Religion & Medicine Committees as evidence for consideration by the House of Delegates.

REDUCED LSD AND "POT" PENALTIES?

QUESTION AND GENERAL RESPONSE:

Some observers—while endorsing stiff punishment for manufacture and distribution of psychedelic drugs and marijuana—believe the penalties for possession exceed the crime. Present Illinois penalties for first offenses are: Marijuana, two- to ten-years imprisonment for possession, 90 days to one year for use; psychedelic drugs, up to one year for possession or obtainment.

Should ISMS seek amendments reducing the Illinois penalties for first offenses in cases of:

	% of M.D.s OPPOSED
a. Possession or use of marijuana?	52%
b. Possession or obtainment of psychedelic drugs?	64%

BREAKDOWN:

In addition to the other membership categories, the breakdown by "type of practice" is included below because of the interesting comparisons it presents.

	Marijuana	Psychedelic Drugs
By *age:*		
Under 40	51%	63%
40-55	53%	65%
Over 55	51%	62%
By *area:*		
Chicago Medical Society	49%	60%
Downstate	54%	68%
By *Field of Practice:*		
General practitioners	56%	67%
Specialists	50%	62%
By *Type of Practice:*		
Solo practice	53%	64%
Partnership or group	53%	67%
Hospital-based	41%	54%

BACKGROUND:

The ISMS has taken the position that psychedelic drugs and marijuana are hazardous under any conditions and must be controlled.

Last year the society was instrumental in the enactment of the state law banning and penalizing the manufacture, sale and possession of LSD and other psychedelic drugs.

The society's concern with the problem has abided. Its Committee on Narcotics and Hazardous Substances sponsored a National Symposium last spring in Chicago to present varied opinions on the legal, moral and medical implications of psychedelics and "pot."

ACTION TO BE TAKEN:

The Committee on Narcotics and Hazardous Substances may resume its study of the issue this month, said its chairman, Dr. Joseph H. Skom. He expressed deep interest in the survey rsults.

ISMS officers interpret the survey results as an endorsement of present law.

MALPRACTICE SCREENING PANEL?

QUESTION AND GENERAL RESPONSE:

New Jersey's Supreme Court has established a voluntary procedure designed to (a) assist plaintiffs in well founded malpractice suits, (b) discourage potential plaintiffs in unfounded and false claims, and (c) restrain adverse publicity against the physician. A panel composed of two physicians, two attorneys and a judge hears evidence and reviews the claim on a closed-door basis before litigation is pursued. If the evidence indicates a reasonable claim, either a settlement is recommended and made . . . or the state medical society provides expert medical witnesses for a trial. If the evidence shows the claim to be unfounded or false, the recommendation is that no suit be filed; if a suit is filed, the plaintiff must retain a new attorney.

Should ISMS encourage adoption of such a program in Illinois?

% of M.D.s IN FAVOR: 96%

BREAKDOWN:

The "yes" vote was almost identical among all categories.

BACKGROUND:

Malpractice claims, like personal-injury cases, are a growing hazard in this "easy money" era. The Board of Trustees decided that Illinois physicians needed further protection.

Last June an ISMS-sponsored professional-liability program took effect. In addition to providing insurance coverage, it is designed to fight nuisance claims and brighten the legal climate.

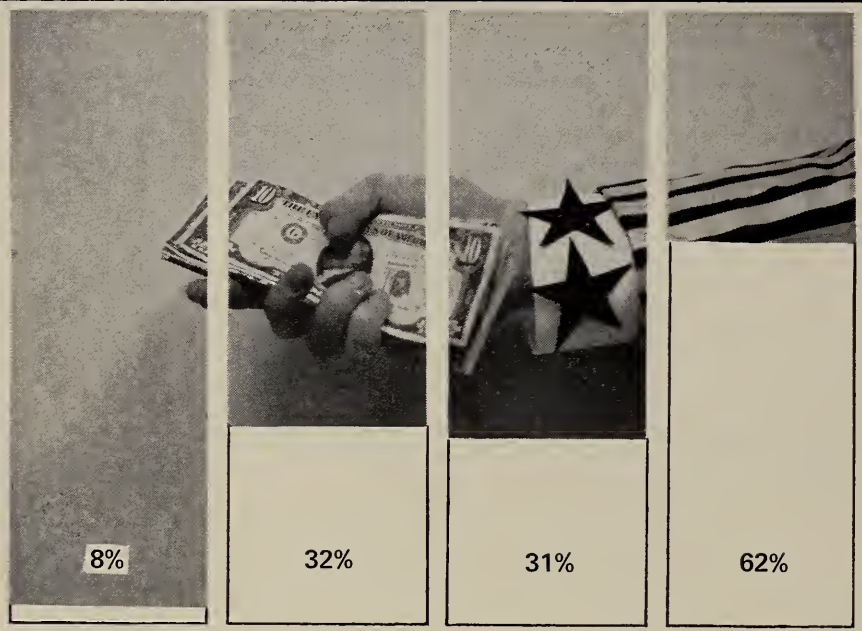
The New Jersey panel plan is a possible further way to bring legal stability.

ACTION TO BE TAKEN:

Armed with the survey results, the ISMS Medical-Legal Council has begun meeting with representatives of the Illinois and Chicago bar associations to assess the panel plan in detail. Finding that nuisance claimants apparently are ignoring New Jersey's voluntary setup, some council members believe any Illinois panel should have a mandate to review all claims.

Any final proposal would be submitted to the Illinois Supreme Court, which—like New Jersey's—can make rules for the entire state-court system.

WAYS TO RAISE STATE REVENUE?



QUESTION AND GENERAL RESPONSE:

The ISMS House of Delegates last May called for state legislation to provide per student subsidies to medical schools. Sources of revenue will have to be considered.

Would you regard any of the steps as acceptable to expand medical training *AND* meet other Illinois needs?

	% of M.D.s IN FAVOR
a. A tax on all services, including medical services?	8%
b. A state income tax?	32%
c. A sales tax increase?	31%
d. Increased earmarked federal grants to the state?	62%

BREAKDOWN:

In the one question approved by a majority—increased earmarked federal grants to the state—the division was:

By *age:*	
Under 40	57%
40-55	64%
Over 55	63%
By *area:*	
Chicago Medical Soc.	70%
Downstate	54%
By *type of practice:*	
General practitioners	55%
Specialists	66%

BACKGROUND:

The ISMS has attacked levies on medical services and drugs as "taxes on illness." It has taken no stand on a sales tax per se, or on a state income tax.

"Increased earmarked federal grants to the state" would not conflict with ISMS policy, provided they entail no federal control over medical education and practice.

Nor has the society expressed any objection to a comparable idea—rebate of federal income tax moneys to the states.

The society endorsed the calling of an Illinois Constitutional Convention, partly in the belief that the state needs a more realistic pattern of taxation.

ACTION TO BE TAKEN:

The ISMS Council on Medical Education is studying the question of revenue for the proposed per-student subsidies, and will have the benefit of the survey results.

PRE-PAROLE PSYCHIATRIC TESTING?

QUESTION AND GENERAL RESPONSE:

Many major crimes of recent years have been linked to brain tumor, mental health and other medical factors. And many such crimes are caused by ex-convicts. Should ISMS encourage legislation requiring neuropsychiatric examination of all criminals prior to parole?

% of M.D.s IN FAVOR: 90%



BREAKDOWN:

By *age:*		
	Under 40	83%
	40-55	89%
	Over 55	95%
By *area:*		
	Chicago Medical Society	91%
	Downstate	89%
By *field of practice:*		
	General Practitioners	91%
	Specialists	89%

BACKGROUND:

The proposal would strengthen and broaden present Illinois law—giving special emphasis to uncovering any murderous and violent tendencies in parole candidates.

As the law now stands, the Parole and Pardon Board may request psychiatric examination of sex offenders prior to parole. Usually at the request of the prison sociologist, such examination may be given in other cases. But there is no uniform requirement.

ACTION TO BE TAKEN:

Study by the Committee on Mental Health could lead to development of legislation to implement the pre-parole proposal.

In addition to pre-parole examination, some observers urge fuller use of psychiatry in earlier stages of confinement. This, they argue, would help convicts attain the emotional health that would make them fit candidates for release.

IN THE **DECEMBER** ISSUE OF IMJ:

Membership Survey Analysis on **SOCIO-ECONOMIC ISSUES**

FILM REVIEWS

A medical motion picture that shows inside views of the stomach has just been completed at Long Beach Veterans Administration Hospital. The viewer sees just what a physician sees when he looks inside the stomach with an instrument called a fiberoptic gastroscope or fiberscope. The new film shows among other things: a benign ulcer, a malignant stomach ulcer, a duodenal ulcer and the stomach after gastric surgery. For more information write: Veterans Administration, Information Service, Washington D.C. 20420.

The National Medical Audiovisual Center has announced the release of several new slide sets and audiotapes including, S-1558-X, "Questions to Answer in Pathology;" S-1559-X, "Hemoglobin;" S-1560-X, "Disorders of Cardiac Rate and Rhythm;" S-1561-X, "The Acutely Ill Baby;" S-1562-X, "Acute Renal Failures." Audiotapes include: A-1565-X, "Headaches;" A-1556-X, "Allergy;" and A-1567-X "Bowel Sounds." Requests for loans should be sent to: National Medical Audiovisual Center (Annex), Chamblee, Georgia 30005.

ILLINOIS ASSOCIATION OF THE PROFESSIONS

Interprofessional

Ralph G. Michael, P.E. and a charter member of IAP, recently spoke at a joint meeting of the Chicago Chapter of the American Institute of Architects and the Chicago Chapter of the Illinois Society of Professional Engineers. Excerpts of his talk will be recognized as pertinent to the interprofessional relationships existing between other professions.

"It is imperative that architects and engineers rise above their professional differences and work together.

1. To oppose legislation which would compromise professional practice as we know it.
2. To combat the efforts of those groups that would encroach into our areas of practice.
3. To mutually contribute to the solution of the problems of society, solutions that only the design professions can provide.

We have all witnessed the imposition of Medicare, with the resultant control, by legislation and administration, of the professional and business practice of a sister profession. Experimentation is being conducted at the local level in some areas with "judicare" and it is not a difficult step from there to "Archicare" or "Engicare."

I can assure you that a Society that is told:

1. It will suffocate from air pollution
2. It will strangle from water pollution
3. It is burying itself in refuse and garbage
4. It finds itself taking longer and longer to go shorter and shorter distances, and
5. It has forty-five million of its people living in—near—or on the brink of poverty,

will not continue to tolerate parochial differences between the professionals—particularly, those professions that must bear the burden of the solution for these problems.

Unless we are willing to establish the necessary dialogue and develop a true cooperative interdisciplinary approach to our relations, we will find ourselves attempting to practice in a hostile framework dictated by others.

The average American housewife controls about 65 horsepower around her house just by flicking switches. Figuring 22 men to one horse, that's equal to 1,430 men (including her husband) being helpful around the house.

Will the Professionals Last the Cultural Revolution?

Luncheon speaker at the Fifth Annual Meeting of the Illinois Association of the Professions on October 11 at the Ambassador East Hotel in Chicago was Dr. Thomas R. Bennett, Professor of Administration and Director of Graduate Studies at George Williams College; Downers Grove. His topic was entitled as above.

Honored guests at the luncheon meeting were the deans of the professional colleges in Illinois and members of the Board of Directors of IAP member organizations.

Spoon River Drug Store

The primary public relations project of the Illinois Pharmaceutical Association for 1968 was the sponsorship and restoration of an 1890 pharmacy at the Sesquicentennial State Fair in Springfield.

A highlight of the ten day Fair, between 800 and 1000 persons passed through the pharmacy each hour, with over 100,000 visitors exposed to the pharmacy.

A permanent installation is being considered.

SOCIO ECONOMIC news

A service of the Public Relations and Economics Division

IDPA Finds M. D. Errors on Some 13,200 Bills A Month

The data-processing machinery of the Illinois Department of Public Aid rejects about 14,500 of the 100,000 physicians' bills fed into it monthly. Some 13,200 of the rejections are due to erroneous information on the bill. The rest result from complications that require individual consideration. These figures were given by Robert G. Wessel, chief of the IDPA division of medical administration, at ISMS workshops on government health programs in Carbondale and Alton. The workshops—scheduled for all areas of the state—are making physicians and medical assistants more expert in claims procedures.

ISMS To Be Friend of Court in Anti-Fluoridation Case

The ISMS Board of Trustees has approved society intervention as *amicus curiae* (friend of the court) in the first suit to challenge Illinois' new Fluoridation Act. A group known as the "Illinois pure water committee" filed the suit in Madison County. Dr. Franklin D. Yoder, state public health director, asked ISMS to intervene in cooperation with the Illinois State Dental Society. The 1967 act, backed by ISMS and ISDS, provides for addition of 0.9 to 1.2 milligrams of fluoride per liter to public water supplies "to protect the dental health of all citizens, particularly children."

State "Health Guides" Serve East St. Louis Poor Area

East St. Louis is a pilot area for a State program of "health guides" who spread health information among the poor. The guides are recruited from disadvantaged neighborhoods and thus gain ready acceptance in them. In addition to familiarizing the poor with available services and facilities, they are to report to service agencies on the conditions and needs they encounter. Lynford Keyes, chief of the Bureau of Health Education, Illinois Department of Public Health, described the project at the ISMS Leadership Conference last month in Springfield. He said it soon would be extended to other areas. The Kerner Commission report—to which Keyes referred—said the relative lack of health in urban ghettos springs partly from "lower utilization of medical services."

New Emphasis Planned in Chicago Health Centers

The Chicago Board of Health plans to establish neighborhood health centers in conjunction with small community hospitals and neighborhood physicians. Dr. Jack Zackler of that agency told the ISMS Leadership Conference. This step, he said, would have an all-around favorable effect on

the community health pattern. The first center is programmed for the Englewood district. The plans, Dr. Zackler noted, are not conditional on Office of Economic Opportunity grants, which helped finance a center connected with Presbyterian-St. Luke's Hospital.

Major Medical Plan Renewals Hold Steady After Rate Hike

Subscribers to the ISMS-sponsored Group Major Medical Program have responded agreeably to the premium rate increases that took effect August 1. For the policy year which began then, the number of non-renewals is only 3 per cent, the same as in previous years. Ernest T. Luehr, president of Parker, Aleshire & Co., which administers the program, gave this report to the ISMS Committee on Economics & Insurance. He also noted that the program paid out more than $150,000 in claims from August 1, 1967 to last July 31.

ISMS Malpractice Program Untouched By Rate Trend

Stock insurance companies belonging and subscribing to the Insurance Rating Board raised their premium rates on malpractice coverage October 2 in 28 states. Their increase on the basic limits ($5,000 each claim/$15,000 aggregate claims) was 20 percent in Illinois; the range was from 10 per cent in Maine and Oklahoma to 100 percent in Vermont. In Illinois and the other states, there was a 50 per cent increase on coverage above the $5,000/$15,000 limits. Not affected is the ISMS professional-liability insurance program, which took effect in June; its rates cannot be raised without society approval.

Advisory Committee to IDPA Proposes Podiatry Policy

The ISMS Advisory Committee to the Illinois Department of Public Aid has proposed a policy for the recognition and reimbursement of podiatrist services in public-aid cases. Under the proposal, payments would be made for all Illinois-licensed services of the podiatrist EXCEPT routine foot care, routine *hygienic* foot care, flat foot conditions, subluxations of the foot, plastic operations (unless necessary to correct traumatic injury or congenital deformity evidenced in infancy), home calls if for other then surgical service, and services provided as surgical consultant or assistant. The committee asked IDPA to implement the proposal, which calls for payment on a usual-and-customary fee basis.

Health Care Now Receiving 74% of U.S. Grants to States

More than $11 billion of the $15 billion in Federal grants to states and localities last year was for health care, the Health Insurance Institute reported. The health grants are for public aid, research, air polluion, sanitation projects, hospital and medical construction, and the like. In 1960 these accounted for only $3 billion of the $11 billion grant total.

Governor Announces Boost in Alcoholism Agency Grants

Governor Samuel H. Shapiro has announced the award of $197,000 in State grants to community alcoholism agencies for the fiscal year that started July 1. The money—$27,000 more than last year—will go to 17 alcoholism agencies for development of new programs and techniques in treatment and care, and for community education. Localities will provide $178,561 in matching funds.

—By DON B. FREEMAN

Membership Forum

To All ISMS Members:

YOU are the most important member of professional medicine in the state of Illinois. Your opinion is of vital interest to your fellow practitioners. The ultimate objective of the Illinois State Medical Society and the *Illinois Medical Journal* is to serve you.

With this in mind, the ISMS Publications Committee has established this "Membership Forum" as a medium through which you may express your opinion and comment.

This Forum may include communications pertaining to any topic and will not be strictly a "letters to the editor" section. If, for example, you would like to express an opinion regarding pending legislation, this might be published here. Or, if you disagree with the substance of a Journal article, this will afford the opportunity of stating your view or experience. Socio-economic factors being of such importance today, you may want to ask what others are thinking or postulate on solutions.

Of course, not every communication can be published. Certain of them may not warrant publication. Others may not be usable for professional or legal reasons. But we do invite your communication. You need not have your name published, if such is your desire and it is so stated; but anonymous letters will not be accepted. Communications should not exceed 300 words in length. The right of editing or condensing is reserved. If the matter is of sufficient magnitude to warrant referral to an ISMS committee or some official agency, such will be done and the inquiry and answer will both be published.

This new section in the IMJ is being established as a service to you, the physician reader. Send your communications to: Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago, 60601.

Jacob E. Reisch, M.D.
Secretary-Treasurer, ISMS
Chrm., Publications Committee

What the Student Should Know

"It is the responsibility of a Faculty of Medicine to instruct its students in the pharmacology and therapeutic uses of narcotics, amphetamines, and barbiturates and to impress upon them their addictive and habit forming properties. The student should be made fully aware of the particular risks to which the physician is exposed by being legally permitted to have these drugs in his possession. He should be repeatedly cautioned that, when licensed, he should never self-prescribe or self-administer these drugs but should rely on another physician for these services. He should be instructed that the abuse of these drugs is considered to be an offence which could result in the loss of his license."

The public is becoming aware of the harmful effects of excessive use of alcohol and tobacco, both of which are available for purchase without special permission. Federal and provincial governments tax the consumer heavily for his fun or folly. But the same governments reserve to Doctors of Medicine the responsibility of placing in the hands of their citizens the narcotic and controlled drugs which, if used wisely, may promote health, but which, issued without discrimination, may induce unhealthy dependence. The medical profession must respect this responsibility if it is to continue to hold the respect of governments and of the community. To teach this responsibility is the duty of the medical school. (G. H. Ettinger, The Problem of Overprescription. **Addictions** (Addiction Research Foundation of Ontario) [Summer] 1968; 15:2; pgs. 9-11).

In peptic ulcer: the antacid puzzle



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aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Clinics for Crippled Children

Twenty three clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. There will be fifteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Dec. 4—Rock Island Cerebral Palsy—Foundation for Crippled Children & Adults, 3808 Eighth Avenue
Dec. 4—Carmi—Carmi Township Hospital
Dec. 4—Alton Rheumatic Fever & Cardiac —Alton Memorial Hospital
Dec. 4—Hinsdale—Hinsdale Sanitarium
Dec. 5—Effingham General—St. Anthony Memorial Hospital
Dec. 5—Springfield General—St. John's Hospital
Dec. 5—Lake County Cardiac—Victory Memorial Hospital
Dec.10—East St. Louis—Christian Welfare Hospital
Dec. 10—Peoria General—Children's Hospital
Dec. 11—Champaign - Urbana—McKinley Hospital
Dec. 12—Litchfield—Madison Park School
Dec. 12—Bloomington—St. Joseph's Hospital
Dec. 13—Chicago Heights Cardiac—St. James Hospital
Dec. 13—Evanston—St. Francis Hospital
Dec. 17—Belleville—St. Elizabeth's Hospital
Dec. 17—Peoria General—Children's Hospital
Dec. 18—Springfield Cerebral Palsy (P.M.) —Diocesan Center
Dec. 18—Aurora—Copley Memorial Hospital
Dec. 18—Chicago Heights General—St. James Hospital
Dec. 19—R o c k f o r d—Rockford Memorial Hospital
Dec. 19—Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
Dec. 19—Elmhurst Cardiac—Memorial Hospital
Dec. 20—Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Crerar Library Designated Regional Medical Library

The John Crerar Library, Chicago, has been designated the Midwest Regional Medical Library by the National Library of Medicine, National Institutes of Health. It will serve medical practitioners, researchers, and educators throughout the five-state area of Illinois, Indiana, Iowa, Minnesota, and Wisconsin. Announcement of a $150,000 grant for the new Regional Medical Library was made jointly by Martin M. Cummings, M.D., Director, National Library of Medicine, and Oliver W. Tuthill, President of the Crerar Library.

The grant, made under authority of the Medical Library Assistance Act of 1965 (Public Law 89-291), will allow the Crerar Library to serve as part of a proposed national medical library network. This network is designed to make information services for activities related to practice, education, and research available to health professionals in all areas of the country.

Crerar's Regional Medical Library services will include the loan of books and, in the case of journal articles, single cost-free copies in lieu of original material; reference and bibliographic services; production of a Union Catalog of books and a Union List of Periodicals in the biomedical collections of libraries in the region served. In addition, Crerar will formulate computer searches of the biomedical journal literature to be processed by MEDLARS (Medical Literature Analysis and Retrieval System) at the National Library of Medicine. The Midwest Regional Medical Library is the fourth of a proposed network of nine or ten to be operational by 1970.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

KANE COUNTY: Carpentersville; population: 22,000. One physician. Nearest hospital at Elgin, 7 miles; population: 52,000. Two prescription drug stores. Office space and housing available. Agricultural and industrial area; 17 churches. Grade and high schools. Recreational facilities include golf course and large community swimming pool. For further information contact: Mr. John W. Franzen, Carpentersville. Phone: 426-4881.

KANE COUNTY: North Aurora; population: 3,500. Fast growing community. Nearest physicians at Batavia and Aurora, 4 miles. Nearest hospitals at Aurora and Geneva, 6 miles. One prescription store. Available physician's office on ground floor. Predominant nationalities: German and Swedish. Many residents commute to Chicago and Aurora. Two small industries. Churches: Lutheran and Presbyterian. Nearest golf course and swimming pool, 10 minute drive. Fast growing residential area; very small business district. For further information contact: Mr. William Rachielles, 12 E. Wilson, Batavia. Phone: 879-1400.

KANKAKEE COUNTY: Bradley; population: 7,000. Trade area, 40,000. Hospitals 2 miles—300 beds. Agricultural and industrial area. Churches: Protestant, Catholic and Jewish. Grade and high schools. Business college and Nazarene College. Kankakee Country Club and Elks County Club nearby. Kankakee, population, 28,000, adjoins Bradley on the south. For further information contact: Dr. Klein, 371 W. Broadway, Bradley.

KANKAKEE COUNTY: St. Anne; population: 1,700. Two physicians until recently; oldest doctor now deceased. Urgent need for replacement. Remaining doctor limits practice due to heart condition. Two hospitals at Kankakee, 14 miles; 60 miles from Chicago. One prescription drug store; 10 year old building available. Equipment for rent or for sale. Predominant nationalities: Dutch, French. Agricultural area. Four Protestant and Catholic churches. Grade and high schools. For further information contact: Mrs. Lesley Hayes, Dixie Highway, St. Anne. Phone: 427-6574.

KENDALL COUNTY: Yorkville; population: 1,800. Trade area, 6,000. Nearest physicians at Plano, Oswego and Aurora. Nearest hospitals at Aurora, 12 miles. Population of Aurora, 70,000. Two prescription stores. Completely equipped medical facility available. Financial assistance if desired. Sources of income: light industry and agriculture. Churches: Protestant and Catholic. Grade and high schools. Nearby recreational facilities: golf, swimming, fishing and boating. County medical society anxious for 1 or more physicians to locate here. For further information contact: Mr. Laurence Henning, President, Yorkville National Bank, Yorkville. Phone: 553-1621.

The following towns in the above-listed counties are also reported to be in need of additional general practitioners. For detailed information contact the county society secretaries shown below:

Kane County: Aurora, Dundee, St. Charles, Geneva and Batavia
Robert G. Stone, M.D.
860 Summit Street
Elgin.

Kendall County: Oswego, Newark and Plano
Joseph L. Daw, M.D.
Oswego.

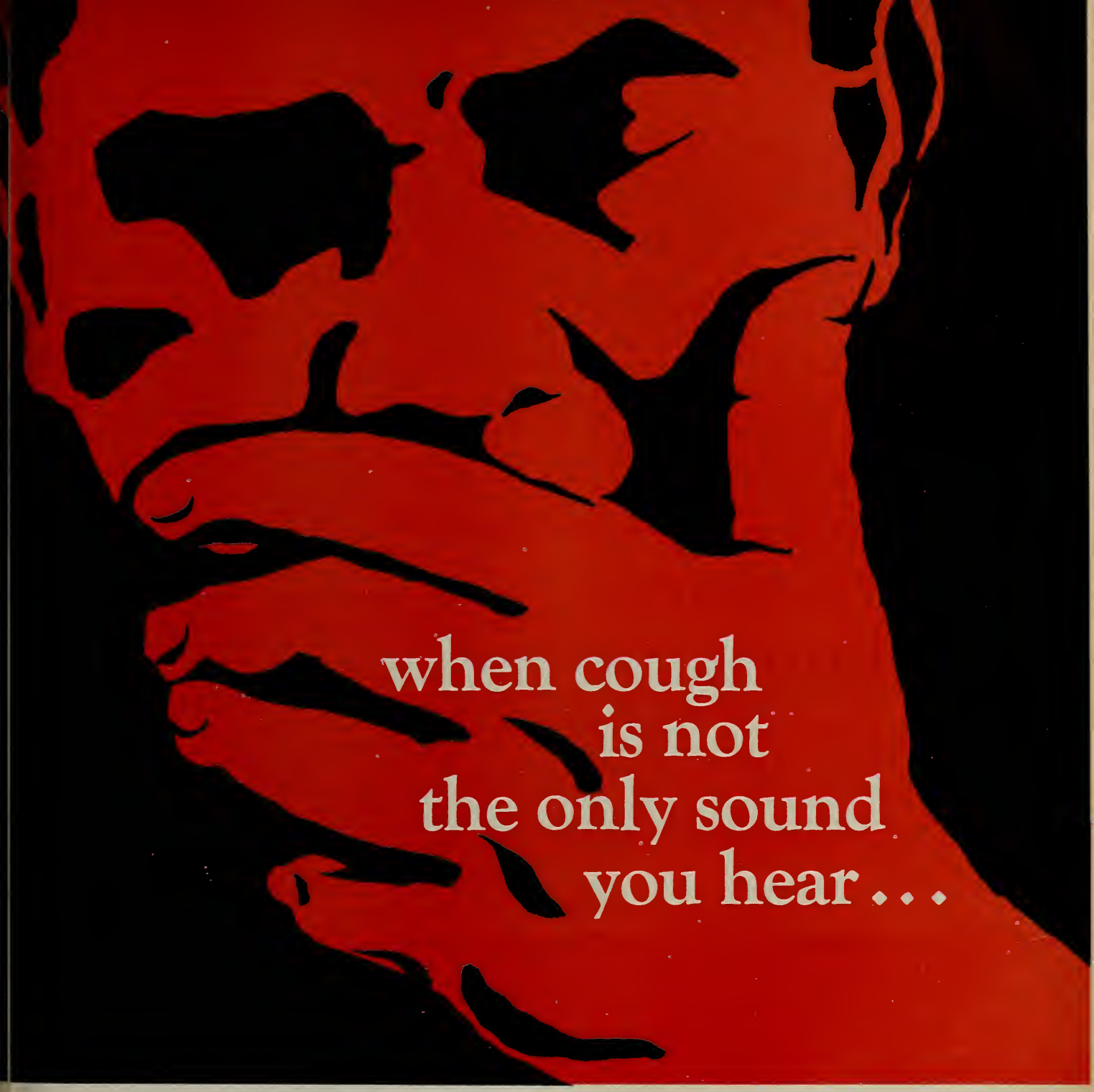
Returning Viet-Nam era servicemen will swell the nation's veterans population 850,000 by 1969.

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

Medicine and Religion

To Better Understand Your Protestant Patient

By Rev. Carl Nighswonger, S.T.M./Chicago

The Protestant patient is first of all a person, and as such, manifests three dimensions of religious need which should be distinguished during any crisis experience.

1) Spiritual Needs: There is a growing appreciation of the spiritual dimension of the "whole" person which represents the individual's need to have a sense of meaning and purpose to his life. One becomes spiritually sick when he has been unable to experience this sense of meaning and purpose in his life.

The level to which an individual has achieved a meaningful and worthwhile life will be reflected in his ability to cope with the crisis of illness. An illness may reach tragic proportions for one whose life is yet "unfulfilled;" or it may be welcomed by the patient whose life has become "empty" of any real meaning.

Sometimes the physician will observe such spiritual conflict, or sickness, through physical and emotional symptomatology. In such instances he should be encouraged to help the patient recognize and deal with the problems of an unfulfilled or meaningless life.

2) Religious Behavior: The patient's religious behavior will reflect the unique function his religion serves in his personality structure. An *intrinsic* religious faith reflects an internalized trust and confidence which enables an individual to cope with life situations realistically and honestly. His religious beliefs will symbolize what he *feels* and *experiences* in life.

The individual with such an *intrinsic* religion usually experiences personal growth and maturity in the process of coping with his illness, even though it be painful and difficult for him. The physician of such a patient should be careful that he does not underestimate the therapeutic resources of the patient's religious faith and practices which will aid in his responsiveness to illness and the treatment program.

On the other hand, the patient whose religion is basically *extrinsic* will find it difficult to experience any personal growth from his illness. *Extrinsic* religion usually represents a defense against reality rather than any genuine acceptance of his life situation.

Few physicians have been spared the exposure to such defensive religious behavior. The incongruence between feelings and actions is usually quite prominent and sometimes leads the physician to either ignore the patient's religious concerns, or to "neutralize" them through a referral to the patient's clergyman.

The physician who recognizes the patient's use of religion, as a defense, gains a further understanding of the personal concerns of his patient and will usually find a sensitive clergyman very helpful in the treatment process.

3) Theological concerns: The third dimension of religious need represents the patient's own theological perspective which determines how he interprets the purpose of life as well as the meaning of his illness.

Often an individual's theological development has been hampered by irrelevant or inadequate doctrines and teachings which sometimes contribute to his lack of meaning and purpose in life as well as his religious defensiveness. (The current "God is Dead" controversy reflects the manner in which theological irrelevance exists for many persons.)

Although most physicians wisely avoid theological issues and discussion with their patients, they should, nevertheless, be aware that the patient's response to his illness and the prescribed treatment program may very well be handicapped by constrictive or conflictual theological beliefs which might very well be based on distortion or misunderstanding.

The physician's respect for the patient as a person demands that he respect the theological perspective of his patient even though it might be personally unacceptable to himself. Such differences need not impede the physician-patient relationship, particularly if the physician has called upon the professional cooperation of an informed clergyman to assist him in the care of the patient.

(Continued on page 706)



"Will I ever catch up on my work?"

Mebaral® usually calms the anxious patient without the degree of languor, or decrease in alertness often caused by other barbiturates.[1] Mebaral is particularly valuable in treating anxiety-tension states *when minimal hypnotic action is desired.*[2] Its sedative action is prolonged[3] and predictable.

Contraindication: Large doses are contraindicated in patients with nephritis.

Warning: May be habit forming.

Precautions: As with other barbiturates, caution is advisable during use in debilitated and senile patients and in patients with pulmonary disease.

Adverse reactions: Although Mebaral is generally well tolerated over long periods, the possibility of idiosyncrasy to barbiturates (as manifested by drowsiness, vertigo, and cutaneous eruptions) should be considered.

Dosage: *Adults,* for daytime sedation—½ gr. (32 mg.), ¾ gr. (50 mg.) and, at times, 1½ gr. (100 mg.), three or four times daily.

References: 1. Musser, Ruth D., and Shubkagel, Betty L.: Pharmacology and Therapeutics, ed. 3, New York, Macmillan Company, 1965, p. 363. 2. Council on Drugs, American Medical Association: New Drugs 1965, Chicago, American Medical Association, 1965, p. 157. 3. Modell, Walter (Ed.): Drugs in Current Use 1966, New York, Springer Publishing Company, 1966, p. 77.

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Mebaral® tablets:
32 mg. . . . . (½ grain)
50 mg. . . . . (¾ grain)
100 mg. . . . . (1½ grains)

brand of
mephobarbital

DEPENDABLE DAYTIME SEDATION

THE VIEW BOX

(Continued from page 644)

Diagnosis: Acute appendicitis.

The striking feature is the presence of a calculus immediately above the right iliac crest. You will also note that there is a vaguely defined mass in the right lower quadrant with absence of gas around the cecum. The presence of a calcification in the region of the appendix in a patient with an acute abdomen is appendicitis until proven otherwise. Usually the presence of a calculus indicates that there is either gangrenous appendix or perforation of the appendix. Other roentgen signs which can be present in acute appendicitis are 1) obliteration of the psoas on the right side; 2) a loss of properitoneal fat line, particularly if there is a laterally placed appendix; 3) an air fluid level will be seen in the right colon in about 85% of the cases on the decubitus film; 4) occasionally scoliosis with retraction of the lumbar spine away from the right lower quadrant will be noted. A barium enema is a very helpful examination in the diagnosis and has been shown to be without apparent danger. The presence of a pressure defect in the cecum with an inverted three pattern has been diagnostic of acute appendicitis. At surgery this patient had a ruptured gangrenous appendix.

Film Review

"The Problem of Chest Pain," an important new medical education film, is now available for loan without charge. Produced in cooperation with Tinsley R. Harrison, M.D., Birmingham, Ala. and the American College of Cardiology, it is being released in conjunction with the publication of Dr. Harrison's book, Principles and Problems of Ischemic Heart Disease. The mode of presentation is unique, employing a film-within-a-film technique. Through this method, the audience is able to view a motion picture, along with Dr. Harrison and a colleague, and at the same time listen to an exchange of pertinent questions and answers between the two. Presented by the Pharmaceuticals Division of Geigy Chemical Corp., the film may be secured by contacting either Geigy's Professional Service Representatives or its Medical Service Department.

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
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ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

"Your Best Foot Forward"

By Susan Piszczek

Medical assistants today are witnessing a growing profession! Sure sounds familiar, doesn't it! Actually, medical assistants form a new profession and even have their own professional organization.

But a medical assistant is a difficult person to describe and define. The American Medical Association's career handbook—*Horizons Unlimited*—says that "the women who staff physicians' offices, whatever the nature of their duties, are properly called medical assistants." That's right, a medical assistant is a secretary, nurse, lab assistant, housekeeper, bookkeeper . . . and performs numerous other tasks.

Another definition says that a medical assistant is "an individual who is supervised by a physician and who performs those administrative and/or clinical duties delegated to her in relation to her specific training and in accord with the respective state laws governing such actions and activities."

The medical assistant meets the challenges posed by the relentlessly-ringing telephone, soothes worried patients, entertains rambunctious or frightened children, conquers the multitude of insurance forms and possibly even assists her boss in the examining room.

Nevertheless, the main job of this medical assistant is to see that the physician's office is managed efficiently. She helps the physician in every way possible so that he is free to concentrate on diagnosing and treating patients.

The AMA realizes that a medical assistant is invaluable to the physician, for a trained office assistant can relieve the physician of needless duties. If she places service above self . . . she is truly a professional . . . and professional individuals find great satisfaction in the dedication and service to others.

It is in this service to others that professionals must strive to meet the acceptable standards of high moral character.

Because of the importance of the job and the relationship with the physician and patient, the assistant at all times must remember to put the best foot forward.

And putting your best foot forward means one must have a pleasing personality, be adept at dealing with people, be neat and accurate . . . and yes, use discretion and good judgment. One must be guided by a code of ethics.

What is ethics? Well, ethics is the study of right and wrong in human conduct. It deals with moral conduct, duty and judgment. Ethics comes from the Greek word *ethos,* and has come to be associated with human customs. Some of these customs are mere conventions such as table manners, modes of dress, forms of speech and etiquette.

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, was a code of conduct setting forth in considerable detail for that era of history the nature of conduct demanded of the physician. The Oath of Hippocrates—a brief statement of principles—has come down through history as a living and even workable statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably around the fifth century B.C. It has remained in Western Civilization as an expression of ideal conduct for the physician. And in 1803, a physician, philosopher and writer, known as Thomas Percival, published his code of medical ethics. Medical ethics serves as a

(Continued on page 702)

Now Continental Bank will give your $20,000 investment the million dollar treatment.

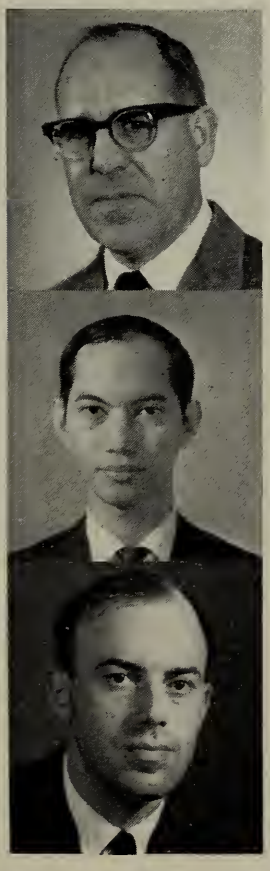


Washing Machine Dialysis With A New Twin Coil Kidney

Use of a domestic washing machine in conjunction with an improved version of the Twin Coil dialyzer constitutes a simple and inexpensive system for hemodialysis. Since installation costs are very low, this method is particularly useful for community hospitals where only a small number of dialyses are anticipated.

By Antonio A. Versaci, M.D.,
Robert V. Soriano, M.D.
and George Dunea, M.B.,
M.R.C.P./Chicago

Hemodialysis with the disposable Twin Coil artificial kidney is currently done with standard equipment specifically designed for this purpose. This consists essentially of a large tank fitted with pumps, a heater and several other devices. The acquisition of such expensive equipment is outside the means of many institutions, and may be difficult to justify if only a limited number of dialyses are anticipated. It is our purpose to present a simple and inexpensive method of dialysis, which utilizes a domestic washing machine in conjunction with an improved type of Twin Coil artificial kidney, the "Ultra-Flo 145". This method significantly reduces the cost of hemodialysis and places this procedure within the reach of any community hospital.



Antonio A. Versaci, M.D. (top) is Director of the Renal Division, Memorial Hospital, Springfield and was the Director of Hemodialysis at Mt. Sinai Hospital, Chicago. He was also Assistant Professor of Medicine at the Chicago Medical School.

Robert V. Soriano, M.D. (center) is a Fellow in Renal Diseases, Mt. Sinai Hospital, Chicago. He holds his M.D. from the Univ. of Santo Tomas, Philippines and served an interneship at Mt. St. Francis hospital in Pittsburgh.

George Dunea, M.D. (lower) is Director of the Chicago Medical School Medicine Section as well as Assistant Professor at Chicago Medical School. His pre-med training is from the University of Sydney, Australia and he holds the M.R.C.P. from London.

Description

A standard tub type washing machine is employed. The agitator is removed. The coil kidney is inserted into a standard Travenol cannister which is suspended in the machine (Fig. 1). The machine is filled with warm water (38-39°C.) through a "fill" hose. For convenience this may be connected to the drain pipe, so that filling occurs by retrograde flow through the drain system. The "fill" hose is then disconnected from the drain pipe: 2.64 liters of Dialysate Salt Concentrate is added and the total volume of dialysate solution is made up to 70 liters. The drain pump is used as a dialysate circulating pump during dialysis by attaching to the drain pipe a rubber hose which is connected to the coil-cannister (Fig. 2). The dialysate is circulated at a rate of approximately 50 liters per min-

Ultra-Flo 145, Dialysate Salt Concentrate, and Travenol are products of Travenol Laboratories, Inc., Morton Grove, Illinois.

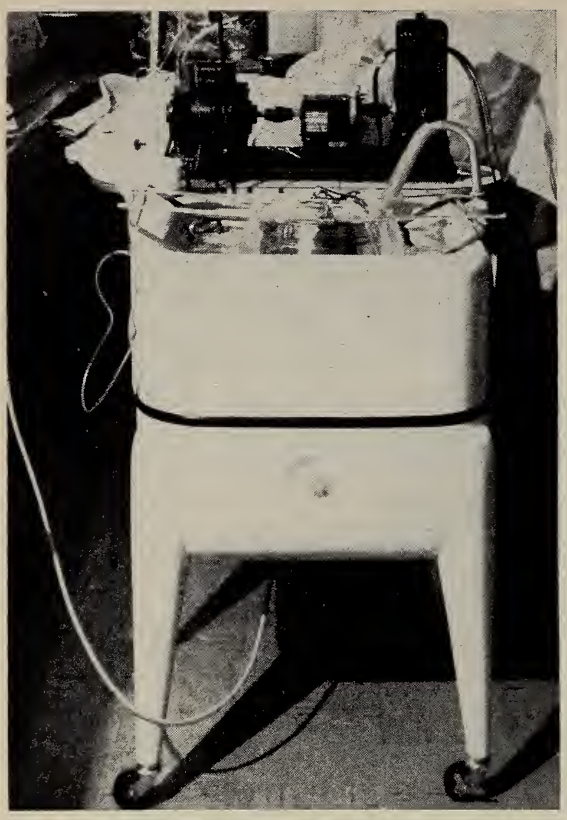


Fig. 1—**Washing machine dialyzer**

ute. Although no heater is used, heat loss from the dialysis fluid is not significant. The bath is changed every 1½ to 2 hours by disconnecting the circulation hose leading from the cannister and attaching the "fill" hose to the drain pipe for draining and refilling. The coil is used with a blood pump, standard connecting sets and manometer, and is primed with saline.

The "Ultra-Flo 145", an improved version of the original Twin Coil artificial kidney, employs a new plastic membrane support and an external compression cuff. It has a high dialysance and ultra-filtration capacity and a reduced blood volume and surface area (See Table). Patients are easily managed by twice weekly six hour dialysis. A further reduction in blood requirements may be achieved by use of a single coil, either alone or by simultaneous dialysis of two patients on one "Ultra-Flo 145" dialyzer; a six hour dialysis is adequate if blood flow rates are high or if the patient is small, otherwise eight to ten hours of dialysis are needed.

Discussion

The concept of utilizing domestic washing machines for dialysis was originated by Nosé in 1961,[1] and more recently adapted

TABLE

	Original Twin Coil	"Ultra-Flo 145"	"Ultra-Flo 145" Single-Coil
Surface Area (M 2)	1.9	1.45	0.725
Priming Volume (c tubing)	1100	500-600	350-400
Urea Dialysance			
Blood flow			
200 ml/min.	125	135	85
250	145	160	105
300	160	180	120
350	170	200	135
400	185	215	150

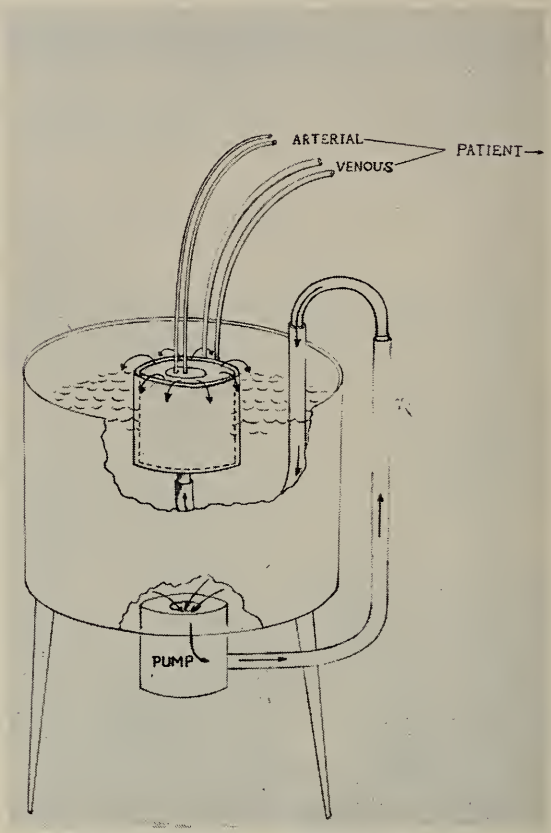


Fig. 2—**Schematic of Dialyze System**

for use with four home made coils.[2,3] In these systems, adequate circulation of dialysis fluid was promoted by the washing machine agitator. The use of disposable coil artificial kidneys is more convenient, and at present only slightly more expensive. However, the larger size and winding of the "Ultra-Flo 145" coil requires a blood pump as well as a pump for adequate circulation of the dialysis fluid. The latter is easily achieved by use of a rubber hose from the drain pump.[4]

In our experience, dialysis with a washing machine is as effective and convenient as the standard methods. In fact, the absence of multiple switches makes it easier to operate. While dialysis with the com-

plete "Ultra-Flo 145" is rapid and efficient, further reduction in cost may be achieved by use of a single coil only, or by simultaneous dialysis of two patients on one Twin Coil.[5]

The principal initial equipment cost of this system is for the blood pump, since used washing machines are inexpensive. At a time when dialysis equipment is becoming increasingly complex and expensive, we hope that this approach will serve as a stimulus toward the development of less expensive methods of treatment for the many who continue to die from uremia.

References

1. Nose, Y.: On a Portable Type Artificial Kidney Set, J. Japanese Med. Instrument. 31:40-42, 1961.
2. Kolff, W. J.: Introduction of a Simple Artificial Kidney in the United States, Clev. Clin. Quart. 34:151-158, 1967.
3. Khastagir, B., Erben, J., Shimizu, A., Rose, F., Nose, Y., Van Dura, D. and Kolff, W. J.: The Four-Coil Artificial Kidney for Home Dialysis, Trans. Amer. Soc. Artif. Org. 13:14-18, 1967.
4. Simon, N. M., Blondell, N. J. and del Greco, F.: A New Technique for Simultaneous Dialysis of Two Patients with The Twin Coil Kidney, Trans. Amer. Soc. Art. Int. Org. 10:183-185, 1964.
5. Ragde, H., Nakamoto, S. and Kolff, W. J.: Simultaneous Hemodialyses with Twin Coil Artificial Kidney, JAMA 176:668-669, 1961.

Emphysema Second to Heart Disease As Cause of Adult Disability

Emphysema is now second only to heart disease as a cause of adult disability—and its prevalence is still increasing, reports Dr. Benjamin Burrows, Associate Professor of Medicine at The University of Chicago.

Although the precise cause of the disease is still uncertain, Dr. Burrows points out that there is a clear association with cigarette smoking and a very suggestive relationship to air pollution.

In addition, genetic factors, respiratory infections, and socio-economic conditions have been implicated in the disease.

Dr. Burrows believes it is more accurate to refer to the condition which often leads to irreversible airways obstruction as the emphysema-bronchitis syndrome.

In the past, chronic bronchitis has been a clinical condition characterized by chronic cough and expectoration of uncertain cause. Emphysema, on the other hand, has been characterized by dilation of the lung's terminal air spaces with destruction of their walls.

Many patients have features suggesting a mixture of the two conditions. Because of the uncertainty of cause, the two may well be manifestations of the same or related problems.

Reported deaths from the condition, whatever its cause, have doubled every five years since 1945. The true death rate, according to Dr. Burrows, undoubtedly exceeds that of lung cancer.

Dr. Burrows has been conducting extensive research on the emphysema-bronchitis syndrome for six years.

In the U.S., the more common pattern involves a slowly developing airway obstruction which begins in early adult life and becomes recognizable on physiological testing by the age of 30 or 40. In these individuals, expiratory flow rates fall two to four times as fast as in the general population. However, it takes 20 to 40 years for these individuals to develop sufficient airways obstruction to produce chronic labored breathing.

Patients with this pattern of the disease generally complain of weakness and dyspnea (labored breathing). A mild cough often begins after the onset of measurable ventilatory impairment, but it may come before clinical dyspnea.

The second pattern of the disease seems to begin earlier, often in childhood. It is characterized by recurrent respiratory infections, recurrent airway obstruction, and early chronic bronchitis.

Dr. Burrows cautions that once chronic obstructive lung disease has developed, there is a distressing tendency to regard it as untreatable. When this critical obstruction has developed, there should be a vigorous and prolonged medical program to be certain the disorder is irreversible.

The major principles in treating these patients are to take an active approach to therapy, discourage premature invalidism, and avoid dependence on expensive gadgets or treatments of unproven value, especially when these are used in place of simpler and more easily administered therapeutic measures, Dr. Burrows added.

IDPA | Illinois Department of Public Aid
Payment Procedures and Policies Explained

Harold O. Swank, Director
Illinois Department of Public Aid

Part I of a Series

On Jan. 1, 1967, the Illinois Department of Public Aid adopted a new procedure for paying physicians for medical care rendered to recipients of public assistance. Arrived at jointly with the Illinois Medical Society, the procedure called for physicians to bill IDPA's Springfield Office directly, charging usual, customary and reasonable fees.

The then new procedure was discussed in principle by Public Aid Director Harold O. Swank in the February, 1967, issue of the *Illinois Medical Journal*. At that time it was pointed out that the procedure, being new, would be subject to evaluation and refinement once sufficient experience had accrued to assure proper judgment. Consequently, formal and informal discussions have taken place periodically between IDPA staff and members of the ISMS Committee on Usual and Customary Fees. And now, some eighteen months later, it is apropos to discuss areas where problems continue to occur and, for the benefit of all, to answer those questions most frequently asked by individual doctors. But before doing that, a brief history of the procedure and a resumé of public aid programs are essential for overall perspective and understanding.

Prior to Jan. 1, 1967, physicians sent their bills to the appropriate county department of public aid where they were reviewed for such factors as eligibility of the patient, presence of needed case data, and charges not to exceed the flat rates mutually agreed upon in 1958 by ISMS and IDPA. The counties then forwarded the screened bills to Springfield for final review, compilation, and payment. Fees to fit unusual cases, errors in billing, and other administrative problems were usually settled at the local level in conjunction with the County Medical Advisory Committee. The more difficult problems—especially those involving fees—were taken up with ISMS for discussion with IDPA at the state level.

The procedure now in effect offers significant improvements. By adopting "usual, customary, and reasonable" fees, doctors are assured of a more realistic return for their services as the former, flat rates were obsolescent and were generally less than the fees charged patients in the private economy. Also, as part of the payment improvement, IDPA lifted the restrictions which limited, under certain conditions, the amount of services—number of office calls or visits—for which it would pay. The new fee rates closely approximate those governed by Title XVIII (Medicare) which became effective July 1, 1966, under the U. S. Social Security Act.

Also, direct billing plus computer processing can promote faster handling and prompt payment. However, the speed factor is provisional, depending on whether or not bills reflect precisely all case identification data (recorded at the top of Form 132) and whether or not all medical services are properly coded and, if necessary, explained. **Bills which do not fulfill these requirements cannot be computer processed.** Some of them—those with errors which can be detected visually—are screened out during the initial clerical review which all bills undergo, and those not so detected are later rejected by the computer.

Bills having errors involving medical procedures receive individual consideration by professional staff. Those with errors of case identification receive manual processing by IDPA clerical or technical staff, after which most can be machine processed. But all manual or individually considered actions cause delay. Throughout this article —to be serialized in several consecutive issues of the *Illinois Medical Journal*—there will be emphasis and detail on how to achieve the desired accuracy in billing for physicians' services and dispensed drugs. The objective is mutual—doctors want to be paid accurately and promptly and the

IDPA wants to pay them accurately and promptly.

For the benefit of all physicians—particularly those who have just entered into practice in the state—a brief resume of IDPA programs follows. There are two broad classes of needy people who are entitled to care under the Medical Assistance (Title XIX) program. First, there are people who lack the income and assets to meet basic living costs and medical care when they get sick. These cases are known as grant cases because during eligibility they receive a monthly financial grant. Such cases include recipients of Old Age Assistance, Blind Assistance, Disabled Assistance or Aid to Dependent Children. The other broad classification is termed Medical Assistance-No Grant and refers to people who have sufficient income or assets to pay for regular living costs but lack the means to pay for medical care, including drugs, when they become ill.

These five categories—OAA, BA, DA, ADC and MA-NG—are funded 50/50 with federal and state money. They are not to be confused with General Assistance or Aid to the Medically Indigent (also under General Assistance). The latter two are locally administered programs using either local revenue or a combination of state and local funds. Eligibility for GA or AMI is determined by the local township supervisor or the commissioner in commission type counties.

How Does One Define Usual, Customary, and Reasonable Fees?

The basic definitions of usual, customary, and reasonable fees are contained in the Medicare Act. The definitions were reviewed and accepted for implementation by ISMS in its meeting on Jan. 16, 1966. The "usual" fee is that fee usually charged for a given service by an individual physician to his private patient (i.e., his own usual fee). A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county). And a fee is "reasonable" when it meets the usual and customary criteria or—in the opinion of the responsible local, district, or state medical society review committee—is justifiable considering the special circumstances of the particular case in question.

How Were These Fees Determined?

The Society's Committee on Usual and Customary Fees surveyed Illinois doctors in the fall of 1966, asking them to list their usual, customary and reasonable fees for a wide range of medical services corresponding to the services listed in the first edition of the "Current Procedural Terminology" booklet published by the American Medical Association. Not all the doctors queried answered the survey but there was sufficient response for ISMS's committee to negotiate with the IDPA to establish the usual, customary and reasonable fees *prevailing in each county and for the state as a whole. Fees varied by doctor and by geographical area and thus it is possible for adjoining counties to differ on prevailing fees.*

Are The Fee Schedules Obtained In The 1966 Survey of Illinois Doctors Still In Effect? May Fees Be Revised?

Yes, for the most part the fees found by survey are still in effect. However, fees on some individual procedures have been revised upward. Complicated or very unusual procedures receive individual consideration and are decided on after thorough professional medical consultation.

Should a doctor be dissatisfied with the amount he has received for a service he may communicate his thoughts to the IDPA in Springfield. The IDPA first checks the bill to see if it was coded and computed properly. If a coding error was made the original payment is revised. If the payment was correct by IDPA standards the doctor is so notified. If still dissatisfied he may consult ISMS's local county or regional committee which deals with government agencies. Such appeals are now rare and seldom if ever involve the frequently used procedures.

Then A Doctor May Not Be Paid The Full Amount He Bills IDPA?

The IDPA currently pays doctors at about 93.6 percent of charges as billed.

Each bill is considered in light of three factors—the doctor's usual, customary and reasonable fee, the prevailing fee for the county, and the prevailing fee for the state. IDPA pays the lowest of the three rates.

Is There Any Value In A Doctor Continuing To Bill At His Usual And Customary Fees Even Though Experience Shows That Some Charges Will Be Reduced?

Yes, As already mentioned, payments have averaged 93.6 percent of charges. Also, the computer records fee profiles on individual doctors and are the basis for fee analysis. The accumulated medical trends together with the medical characteristics of recipients are invaluable in planning long range medical programs and securing the necessary appropriations.

What Questions Are Asked Most Frequently By Doctors?

Understandably, doctors have questions from time to time due, if nothing else, to the sheer magnitude of the Medical Assistance program. Then, too, doctors must keep abreast of the entitlements, fees and procedures of other programs to include Medicare, Blue Cross/Blue Shield, and a host of private health insurance programs, both group and individual.

This serialized article is one way to help assure two-way communications channels between IDPA and doctors and between doctors and the IDPA.

There are several broad categories of questions asked and each has its own group of auxiliary questions. One is: why are payments sometimes less than the billing? The principal reason, already explained, is that IDPA considers payment in light of the doctor's usual and customary fee, the prevailing county fee, and the prevailing state fee—as previously defined and determined by survey. Other questions bear on billings: Why is payment sometimes denied or delayed? Why does the computer reject bills? What is the role of the doctor in the patient's eligibility for medical care? What is the procedure for billing IDPA when the patient is also eligible for Medicare? Under what circumstances are payments reduced or denied on billings by the doctor for dispensed drugs or billings by the pharmacist for prescribed drugs? What is the proper way to bill for services when the physician uses one or more assistants? May a general practioner or internist bill for hospital calls while his patient is in the hospital under a surgeon's care? May a doctor bill for services rendered a year or more ago? Is the "Current Procedural Terminology" code book undergoing revision to better define terms and to provide more alternatives for coding complicated cases? Why is there a difference in billing procedure for tests performed by an Independent Certified Laboratory and tests performed by a hospital pathologist?

These and other questions will be answered in detail in later installments.

Immunity In Cancer

Increasingly, research interest in cancer is centering on attempts to unravel the relationship between the immune progess and protection from or induction of malignant change. The coincidence of abnormalities in the defense systems of the body and malignant disease is not random. It has been recognized for a long time that various neoplasms, particularly lymphomas, appear to induce immunologic abnormalities including 'autoimmune' disease. On the other hand, the possibility that defense mechanisms result in the appearance of malignancy seems logically remote. There are, however, recent experiments in mice and observations in man which suggest both that immune mechanisms can result in changes leading to malignancy and that some initial stress (a virus, for example) may initiate a chain of events leading through 'autoimmune' disease into malignancy. (John R. Durant, "Immunity In Cancer" Highlights, **Delaware Med. Jl.** [Mar.] 1968; pg. 84.)

Medical-Legal Problems of Illinois Physicians

Liability of Physicians in Committing Patients to Mental Hospitals

By Frank M. Pfeifer, Legal Council, ISMS

The IMJ, in attempting to bring to the physicians of Illinois information that is of importance and concern to them, will carry in future issues medical-legal articles written by the legal counsel of the Illinois State Medical Society. These articles will be based upon actual experiences, questions and problems as they arise from time to time throughout the State. Answers to individual queries and specific problems cannot be answered in these columns.

The present Mental Health Code (Paragraph 1-1 through 427, Chapter 91½, Illinois Revised Statutes, 1967), which was adopted by the Illinois Legislature in 1967 covers the commitment, care and treatment of persons who are in need of mental treatment or who are mentally retarded and follows very closely the Mental Health Act of 1963.

Under the Mental Act, or Code as it now exists, there are several different ways in which individuals in need of treatment may be admitted to a mental hospital; namely, informal admission, voluntary admission, admission on certificate of physician, emergency admission and admission by order of court. Under several of the types of admission, a certificate of a physician licensed to practice medicine in all of its branches is a necessary requirement.

There seems to be a feeling on the part of some physicians in Illinois that they are not qualified to make an examination of the patient and, thereafter, to sign a certificate of need for hospitalization unless they are either psychologists or psychiatrists, and further feel that to sign such a certificate might subject them to liability and damage suits. While the Mental Code does mention both psychologists and psychiatrists, there is no requirement that the physician making the examination and signing the certificate need specifically be trained in either of these fields of medicine; but instead, *all physicians authorized to practice medicine in all of its branches are specifically authorized to perform this necessary service.*

The certificate needed for hospitalization which the physician signs after examining the patient (Form 68-MHC-4) contains a box indicating whether he is licensed to practice medicine in all of its branches or whether he is a psychologist or psychiatrist. This information is for the use of the mental hospital after the patient has been admitted and in no way qualifies the right of the physician to make the examination and sign the certificate. Perhaps it is due to this language of the certificate; perhaps it is due to the fact that psychologists and psychiatrists are mentioned in the Act; but for some reason, many physicians are fearful of signing the certificate and are refusing to perform this very necessary service.

The word physician is used throughout the Act and such an individual is author-

ized to make the necessary examinations and sign the certificate. Under Section 1-14 of the Act, a physician is defined as follows: "Physician" means any person licensed by the State of Illinois to practice medicine in all its branches and includes any person holding a state hospital permit or temporary certificate of registration as provided in the Medical Practice Act.

We find from reading the entire Mental Health Code that physicians, as defined above, are authorized to make the necessary examinations and to sign the certificates and this being the case, there could be no liability upon a physician so doing unless it could be shown that he was acting with malice for some ulterior purpose of his own. We have had mental institutions in Illinois for many years and over this period of time, have had many different acts pertaining to the admission of patients into mental hospitals; all of which have had provisions for physicians' certificates when the admission was not upon a voluntary basis. *A review of the decisions of the Appellate Courts and the Supreme Court of Illinois does not reveal a single case of a physician ever being held liable for committing an individual to a mental hospital.*

Over and beyond everything said above, Section 12-11 of the present Mental Health Code provides as follows: "All persons acting in good faith and without negligence in connection with the preparation of applications, petitions, certificates or other documents for the apprehension, transportation, examination, treatment, detention or discharge of an individual under the provisions of this Act incur no liability, civil or criminal, by reason of such Acts." If there was any possibility of liability, it has clearly and definitely been removed by the immunity provision quoted next above.

While it is true in Illinois that physicians have the legal right to pick and choose their patients and do not have to provide medical services for a given individual if they do not desire to do so, wholesale refusal to examine individuals for determination of their mental condition might cause the Legislature to change the law in a manner which would not be to the liking of the physicians. It is the recommendation of this writer that the physicians in Illinois cooperate with the public authorities in this most important and necessary medical service. Lest anyone be confused, let it be said that while a physician in Illinois has the right to pick and choose his patients, once a physician accepts the patient, this patient cannot be abandoned by him until a suitable replacement has been obtained. This means that a physician treating a mental patient is under a duty to sign the certificate if admission to a state mental hospital becomes necessary.

A copy of the certificate needed for hospitalization, which the examining physician is called upon to sign, is set forth below. You will note that under No. 1 you indicate whether you are a physician licensed to practice medicine in all of its branches or whether you are a psychologist under the Illinois Psychologist Registration Act or whether you are a psychiatrist. (Definition of psychiatrist in Section 1-15 is: "psychiatrist" means a physician as defined in Section 1-14, who devotes a substantial portion of his time to the practice of psychiatry and has practiced psychiatry for one year immediately proceeding the certification of any patient.") Under No. 2 the physician states the name of the person examined, the time and date and the results of the examination. Under No. 3 the physician states the type of care which should be received by the patient and then indicates, in the appropriate box, the type of admission for which the certificate is used. This last item is not of any real consequence to the physician and would not need to be checked by him; for his duty ends when he reports his findings from the examination and indicates the type of treatment he feels is appropriate.

The physician, in signing, names his degree which in the case of a physician licensed to practice medicine in all its branches, should be "M.D."

Circuit and Associate Judges in Illinois have the power to order a physician to make an examination, to report his findings and to testify; and in those rare situations where a physician is so ordered, he of course must comply, even though he would prefer otherwise for to refuse would subject him to contempt of court which can carry a jail sentence.

CERTIFICATE OF NEED FOR HOSPITALIZATION

I CERTIFY:

1. (Check appropriate box)

☐ I am licensed to practice medicine in all its branches in Illinois.
☐ I am certified as a psychologist under the Illinois Psychologist Registration Act.
☐ I am a psychiatrist as defined in Section 1-15 of the Mental Health Code.

2. I personally examined ..... at .....m.,

on ....., 19..... and found (describe symptoms—attach separate sheet if necessary):

3. It is my opinion that he is

☐ in need of mental treatment ☐ mentally retarded

and that he

☐ be hospitalized in a suitable public or private hospital
☐ be admitted to a hospital immediately as an emergency for the protection from physical harm of himself or others
(If patient is to be admitted as an emergency this examination must be made within 72 hours of admission)
☐ be placed in the care of a relative or other person

This certificate is issued for: (check one)

☐ attachment to application for admission (MHC-3)
☐ attachment to petition for admission as an emergency (MHC-7)
☐ attachment to petition for hospitalization on court order (MHC-7)
☐ court ordered examination
☐ inclusion in the hospital record as psychiatrist's examination

.....
(name and degree) (office address-street)

....., Illinois. .....
(city) (telephone number)

Hold the Physician in honor, for he is essential
to you, and God it was who established his profession.
From God the Doctor has his wisdom.
Thus God's creative work continues without cease.
He who is a sinner toward his Maker will be deficient
toward his Doctor.

Author Unknown



MEETING MEMOS

Nov. 19—The New York University School of Medicine will present the 16th Annual Sigmund Pollitzer Lecture. "The Hormonal Control of Sebaceous Gland Function in Man," will be this year's address given by John S. Strauss, M.D., professor of dermatology, Boston University; 8:15 p.m.; Hall Auditorium, 550 First Ave., New York City.

Nov. 22-24—"Psychiatry and the Internist," will be the topic of the address given by Richard E. Hicks, M.D., and Paul Jay Fink, M.D., at this month's meeting of the Hahnemann Medical College and Hospital at the Marriott Motor Hotel, Philadelphia, Pa.

Dec. 1—To be held in Miami Beach, Fla., the Tenth National Conference on the Medical Aspects of Sports. Sponsored by the American Medical Association. Featured luncheon speaker will be Payton Jordan, head coach of the 1968 U.S. Olympic Track and Field Team.

Dec. 1-4—The American Medical Association will hold its 22nd Clinical Convention in Miami Beach, Fla. This year's convention will feature over 125 scientific exhibits.

Dec. 16-18—The Twenty-Second Postgraduate Assembly in Anesthesiology. Sponsored by the New York State Society of Anesthesiologists. To be held in New York City.

Your Best Foot Forward

(Continued from page 689)

guide for physician's actions in the treatment of his patients.

Medical assistants are the direct link between the physician and his patients . . . between suppliers, drug detail men, professional associates, and sometimes even his family. Because of the nature of the job, it is mandatory that discretion and good judgment be employed . . . just as the physician, the assistant must be guided by a code of ethics.

Medical assistants have a highly responsible job. They are an important member of the medical team. They are professionals. They are the link between the physician and his patients.

When guided by ethics in everyday life, your best foot WILL BE FORWARD!



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...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
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Folic Acid	0.05 mg
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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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OBITUARIES

Dr. Nelson W. Barker, a native of Evanston and retired staff physician at the Mayo Clinic, died Sept. 13 at the age of 69.

***Dr. Jerome J. Burke,** Round Lake, president of Lake County Tuberculosis Sanitarium, died Sept. 13 at the age of 45. He was past president of the Lake County Medical Society.

***Dr. John H. Coffey,** Belleville, 52, died Sept. 6. He was a member of the American College of Physicians and a Diplomate of the Medical Board of Internal Medicine.

***Dr. John J. Corbin,** Chicago, died Sept. 13 at the age of 54. He was past president of the medical staff at St. Joseph's Hospital.

***Dr. James A. Day,** Springfield, the oldest physician in Sangamon County, died Aug. 30 at the age of 98. He was on the staff of Passavant Hospital and chief surgeon at Our Saviour Hospital and a member of ISMS Fifty-Year Club.

***Dr. Chester W. Fouser,** Chicago, died Sept. 18 at the age of 80. He was a member of ISMS Fifty-Year Club.

***Dr. Elmer W. Hagens,** La Grange Park, died Sept. 20 at the age of 71. He was on the staff of Wesley Memorial Hospital and a member of the department of Otolaryngology at Northwestern University Medical School.

***Dr. Roland A. Jacobson,** Arlington Heights, died Sept.. 28 at the age of 72. He was a member of the American College of Surgeons, retired surgeon and former staff member at Presbyterian-St. Luke's and Resurrection Hospitals.

***Dr. Walburga L. Kacin,** Morton Grove, died Sept. 21 at the age of 88. She was a member of ISMS Fifty-Year Club.

***Dr. Charles O. Lane,** West Frankfort, died Sept. 6 at the age of 92. He had served as Councilor of the 9th District of ISMS, and was past president of the Franklin County Medical Society; a member of ISMS Fifty-Year Club.

Dr. Franklin C. McLean, Chicago, professor emeritus of the department of psychology at the University of Chicago, died Sept. 10 at the age of 80. He was an organizer and director of National Medical Fellowships, Inc., organized the University of Chicago Clinics and was past director of the clinics.

Dr. Joel P. Oliver, Chicago, died Sept. 13 at the age of 58.

***Dr. Sidney Rosenberg,** Chicago, died Sept. 11 at the age of 63. He was on the staff of Mt. Siani and Edgewater Hospitals.

***Dr. Arthur H. Rothenberg,** Des Plaines, died Sept. 13 at the age of 43. He was on the staff at Lutheran General and Holy Family Catholic Hospitals.

***Dr. Lester W. Savage,** East Moline, assistant medical superintendent at the East Moline State Hospital, died Sept. 3 at the age of 57.

Dr. Burton Solar, Chicago, died Sept. 26 at the age of 67.

Dr. Nels M. Strandjord, Chicago, an associate professor of radiology at the University of Chicago's Pritzker School of Medicine, died Sept. 10 at the age of 48.

***Dr. Earl D. Wise,** a practicing physician in Champaign for 51 years, died Sept. 21 at the age of 81. He was a member of ISMS Fifty-Year Club.

*Indicates member of Illinois State Medical Society.

Frontiers of Medicine

Recent advances in medicine for physicians in practice will be presented through the "1968-69 Frontiers of Medicine" program being sponsored by the Committee on Continuing Medical Education of the University of Chicago Hospitals and Clinics.

This series of eight conferences, given on the second Wednesday of each month until May, is designed to provide physicians with a comprehensive review of recent developments, with particular emphasis upon clinical application.

Future programs, acceptable for credit by the American Academy of General Practice, include: Dec. 11, "Malabsorption Problems;" Jan. 8, "Thyroid Disease;" Feb. 12, "Diagnosis and Management of Respiratory Insufficiency;" April 9, "Pathogenesis, Diagnosis and Treatment of Rheumatoid Arthritis;" and May 14, "Management of the Patient with Acute Myocardial Infarction."

A fee of $15 will be charged for attendance at each session. Advanced registration is desirable. For further information contact: Frontiers of Medicine, The University of Chicago, 950 E. 95th St., Chicago 60637.

New Book for Parents

Parents' difficulties in talking to their children about the human body can be easily overcome with the assistance of the American Medical Association's new book, "Your Body and How It Works."

Written in the language of a child in the early elementary years, the book is designed for the parent and child to read together. The entire book fosters a wholesome attitude that the body is a beautiful gift and encourages an interest in taking care of it.

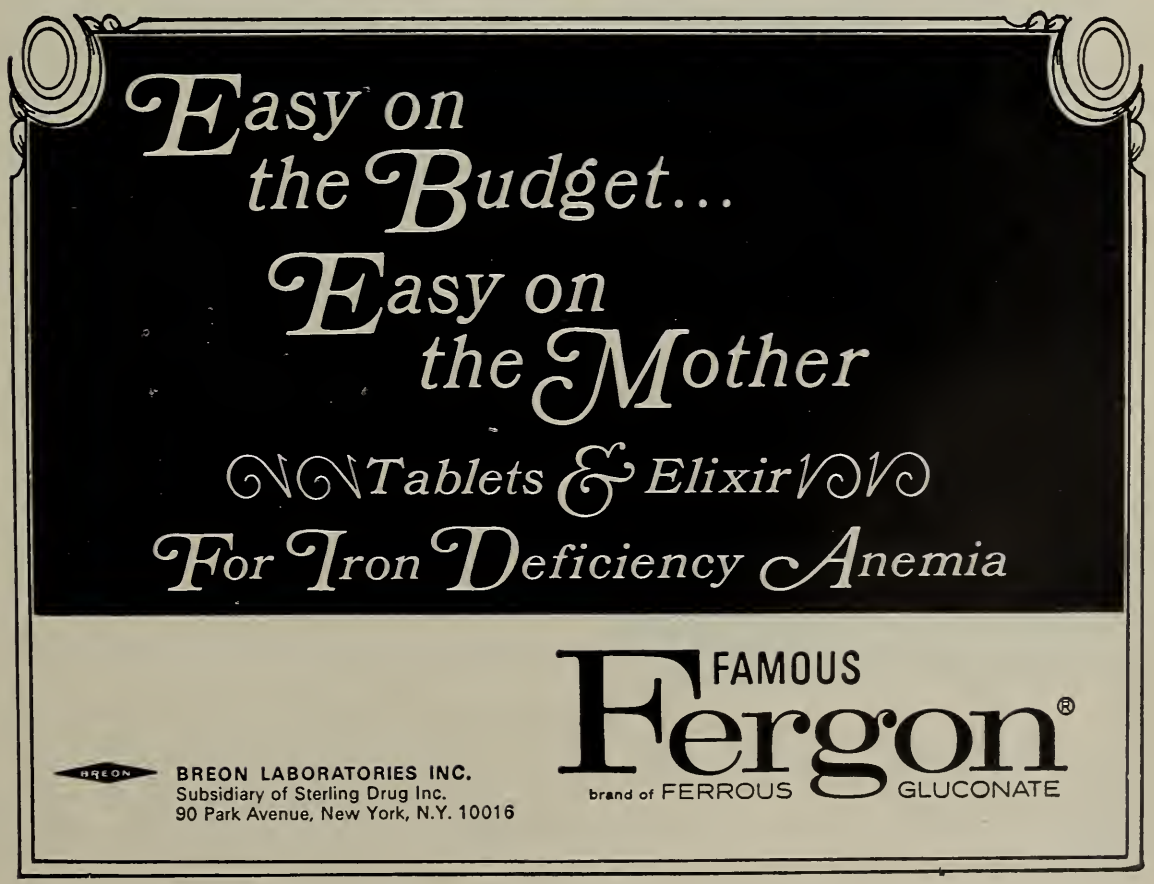
The colorful, 30-page booklet mentions the functions of the exterior parts of the body, along with describing and illustrating the internal systems, such as the heart and circulatory, nervous, respiratory and digestive. The section on the respiratory system describes how the air comes into the body and traces the route of air through the system until it leaves the body. Illustrations of the heart and circulatory system show the mass of blood vessels in the human machine.

Available from the AMA's Order Handling Department, "Your Body and How It Works" is available at: single copies, 45 cents each; 50-99 copies, 43 cents each; 100-499 copies, 41 cents each; 500-999 copies, 39 cents each; and 1,000 or more copies, 35 cents each.

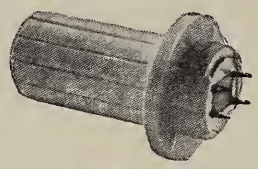
University of Illinois Medical Center Accepts $467,312 in Grants

The University of Illinois Medical Center campus, Chicago, has accepted an overall total of $467,312 in research and training grants for the month of September. Out of 19 grants listed, 17 grants totaling $404,435 were from the United States Public Health Service.

The funds were allocated as follows: $31,638, College of Dentistry; $334,462, College of Medicine; $90,412, College of Nursing; and $10,800, College of Pharmacy. The largest single grant, $102,481, was awarded to Dr. Sheldon Dray, professor and head, Department of Microbiology in the College of Medicine by the United States Public Health Service for "Serum Protein Allotypes."



Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
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(Histoplasmosis—"The Masquerader")



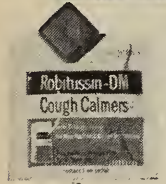
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Over-65 Hospital Population Increases

The nations' over-65 population continued to make increasing use of hospital facilities in the first quarter of 1968, according to Hospital Indicators, a monthly report which appears in HOSPITALS, Journal of the American Hospital Association.

The report noted an 8.4 per cent increase in the rate of admissions of persons 65 and over to community hospitals through the first three months of 1968 over the comparable period of 1967. At the same time, the admission rate for persons under 65 decreased by 0.5 per cent.

In all, patients 65 and over accounted for 20.6 per cent of admissions in 1968's first quarter and also accounted for 33.3 percent of all inpatient days. In the first quarter of 1967, the 65 and over patients were responsible for 19.2 per cent of all admissions and 31 per cent of the inpatient days.

Statistics for March 1968 show that the average length of hospital stay for elderly patients decreased slightly from a February high of 13.7 days to 13.2 days. The February figure was the highest since the start of Medicare in July 1966. Patients under 65 stayed an average of seven days.

Your Protestant Patient

(Continued from page 682)

There is growing recognition of the inherent dangers in "labeling" an individual's religious needs simply because he is a Protestant, or a Catholic, or a Jew. Each person expresses his religious needs in a manner unique to himself and his own life experiences.

What is important is that the physician recognizes the multidimensional character of religious needs and attempts to understand how these needs may be helping or hindering the patient in his illness. Moreover, he should be encouraged to seek the assistance of an informed clergyman whenever he is in doubt as to the religious concerns of a specific patient.

★

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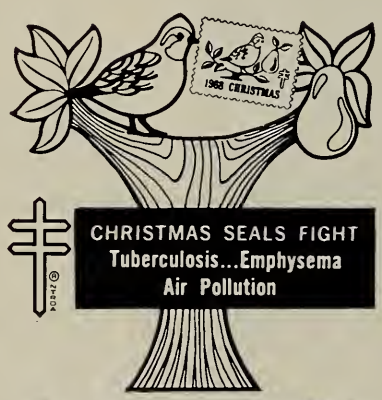
STARTING DATES—1968

SPECIALTY REVIEW COURSE IN ORTHOPEDICS, Nov. 18 & Dec. 9
SPECIALTY REVIEW COURSE IN UROLOGY, Four Days, Nov. 18
SPECIALTY REVIEW COURSE IN SURGERY, Part II, Dec. 2
SPECIALTY REVIEW COURSE IN PEDIATRICS, December 9
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
SURGERY OF COLON & RECTUM, One Week, November 11
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Dec. 9
GYNECOLOGY, One Week, November 11
OBSTETRICS, One Week, November 18
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY, Dec. 10
ULTRAVIOLET CYSTOSCOPY, 1½ Days, November 14
SYMPOSIUM ON SHOCK, Two Days, December 20
ADVANCES IN PEDIATRICS, One Week, November 11
ADVANCES IN MEDICINE, One Week, December 2
CLINICAL NEUROLOGY, One Week, December 2
RADIOISOTOPES, One or Two Weeks, First Monday each Month
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

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IT'S A MATTER OF LIFE AND BREATH

Foundlings Home Openings

There are now a few openings available for young unmarried mothers at the Chicago Foundlings Home. Girls are accepted for residence at the Home after their 6th month of pregnancy, or earlier if need be. Excellent obstetrical and pediatric facilities are available. Social Workers at the Home will make arrangements for adoptions when requested.

The Home was founded in 1871 by Dr. George E. Shipman and has served the community since.

Physicians interested may contact Miss Mavis M. Koopman, 1720 W. Polk Street, or telephone her at TAylor 9-1446.

Beer and Heart Attacks

Increasing evidence of serious heart disease among chronic beer drinkers is the basis of a research program at the University of Minnesota.

According to Carl S. Alexander, M.D., Associate Professor of Medicine, University of Minnesota, principal investigator, 85-90% of the patients at the Minneapolis Veterans' Hospital with primary myocardial disease are chronic beer drinkers, and most of these patients develop alcoholic cardiomyopathy, or alcoholic heart failure.

Major aims of the research, according to Dr. Alexander, are to see if alcohol 1) produces a depletion of necessary elements found in the heart, such as magnesium, potassium and zinc, 2) changes the level of protein, actomyosin and collagen in the heart, and 3) affects heart muscle in other ways.

Researchers have already shown that heart failure symptoms associated with chronic alcoholics include difficulty in breathing, rapidly beating heart, swollen legs, fatigue and weakness.

Heavy drinking seems often to be the one similarity of some patients who sumcumb to the above illness suddenly, yet show no evidence of other types of heart disease such as atherosclerosis, valvular disease, anemia or severe malnutrition.

A $52,685 grant will support the project for the first year. The National Institute of Mental Health plans two additional years of support subject to annual review.

BLUE SHIELD REPORT FOR Illinois Physicians

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 12 December, 1968

Blue Cross and Blue Shield New Small Group Plans

Several new Blue Cross and Blue Shield certificates have been written which provide broader coverage to smaller groups in Illinois. The new health care programs have been designed by Blue Cross and Blue Shield to provide this important segment of the market with a wide selection of comprehensive programs to help finance their health care costs.

Groups as small as four may now benefit from the same scope of coverage offered to most large employee groups. In addition to improved basic benefits, Blue Cross and Blue Shield will extend Major Medical protection as well.

These contracts will provide new coverages for maternity, outpatient diagnostic, and other services previously uncovered or limited by our other contracts.

Two Usual and Customary programs will be offered. One will pay 100% and the other 80% of the Usual and Customary charges of physicians for a wide range of covered services.

Until now, Usual and Customary Blue Shield certificates have only been offered to groups of fifty or more. Blue Shield will encourage its subscriber groups to protect themselves with our Usual and Customary programs in which the basis of payment is related directly to the usual charges of physicians rather than fixed indemnity benefit schedules.

Of course, Blue Shield will continue to offer indemnity programs.

Because the size of a group is not a standard of health care needs, Blue Cross and Blue Shield are making a determined effort to extend more comprehensive health care coverage to all groups regardless of size.

The marketing effort will start shortly and protection under our new certificates will begin early in 1969.

Fall Meetings for Medical Assistants Over

The final Blue Shield meetings for medical assistants were held on November 13 and 14 at the Knickerbocker Hotel in Chicago. Attendance reached close to 500 guests at these two meetings, making a total of 3,000 medical assistants attending from Cook, Kane, DuPage, Lake and Will Counties where Blue Shield serves as Part B carrier for Medicare. All medical assistants were invited to attend one of these meetings which have been conducted by Blue Shield for the past eleven years.

Dr. Leo P. A. Sweeney, President, Blue Shield Plan of Illinois Medical Service, talked to the group several times on Blue Shield's new 65 plan and thanked the assistants for their help this past year. Following the discussion of Blue Shield 65 which was presented by Mr. George Hyland, questions were answered by our panel of experts on matters pertaining to Blue Shield and Medicare.

Mrs. O'Donnell, Special Representative, Professional Relations Department, arranges the meetings which will begin again in early spring for medical assistants in all other counties throughout the State.

We also conduct special two-hour seminars which are scheduled on Wednesdays and Thursdays for medical assistants in our offices which will be announced when the date and time has been set. We encourage all medical assistants to attend so that we may provide them with information to help them carry out their responsibilities for you more effectively.

If your assistants have Blue Shield questions, they may be directed to Loretta O'Donnell, Special Representative, Professional Relations, 222 N. Dearborn.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Q Where do I submit Medicare claims for patients I treat that reside in another state?

A Medicare claims should always be sent to the Medicare office in the area where the physician practices.

Q I have a patient who expired before his bill was paid and he has no known relatives. What procedure do I follow to receive payment? I will accept assignment.

A Complete an SSA Form 1490 Request for Payment in the usual manner. Indicate on it that you accept assignment and attach a statement explaining that the patient has expired and there are no known relatives. This permits the Medicare carrier to make payment for allowable services without the beneficiary's signature.

Q Should I submit a claim each time I see a patient or should I group a number of visits together on one claim?

A Either way is acceptable but by grouping visits together the amount of paper work performed in your office can be reduced. On a multiple visit claim, Medicare needs the date of service, diagnosis and charge for each service before the claim can be processed. If the services you provided extend from one calendar year into the next, it is preferable to submit separate claim forms as they will have to be processed separately.

Q I have a patient who entered the hospital 4 days before he became 65. Is he entitled to Medicare benefits for these 4 days?

A Yes, if he had applied for Part B benefits within the 3 months prior to the month in which he became 65. In such cases coverage begins on the first day of the month he became 65.

Q I have a patient who submitted an itemized bill to Medicare and benefits were paid directly to him. Now I cannot collect for his unpaid bill. What procedure do I follow to get this bill paid?

A In such a situation, a physician can follow the same procedure he uses to obtain payment for his patients who are not covered by Medicare.

Q What procedure do I follow in submitting a claim for a Railroad Retiree?

A Fill out an SSA Form 1490, Request for Payment in the usual manner and send it to Travelers Insurance Co., 175 West Jackson Blvd., Chicago, Illinois.

Medicare Deductible and Co-Insurance Raised

The Social Security Administration has found it necessary to increase the deductible and co-insurance portion of Medicare for which the beneficiary is responsible. Beginning January 1, 1969 the Part A deductible will be raised from $40.00 to $44.00. However, if a benefit period begins in 1968 and extends into 1969, the deductible will still be $40.00.

The co-insurance, the portion the beneficiary pays, from the sixty-first to the ninetieth day of hospitalization will be raised from $10.00 to $11.00 a day. If a beneficiary chooses to use any of his sixty lifetime reserve days, he will be responsible to pay $22.00 a day for each day used.

A beneficiary in an extended care facility, beginning January 1, 1969, will be responsible for $5.50 a day from the twenty-first day to the one hundredth day of care.

These changes represent a 10% increase in the present deductible and co-insurance.

Any changes in the Part B deductible and co-insurance will be announced in December 1968 by the Social Security Administration and will become effective in July 1969.

About Prosthetic Devices

Prosthetic devices which replace an internal organ and its contiguous tissues are covered under Medicare. The replacement and repair of such devices are also covered when done by order of a physician.

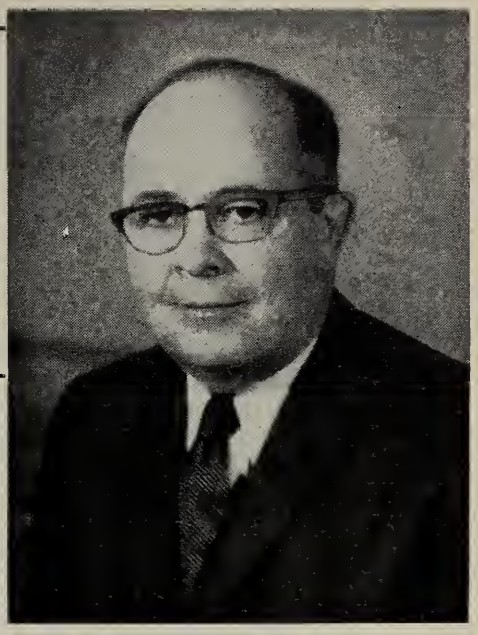
Included in the definition of an "internal organ" are the lenses of the eyes and all or part of the ear and nose. This definition allows Medicare to make payment for the prosthetic lenses used during convalescence from the surgical removal of the eye's lens. The permanent lens needed to restore normal vision after such surgery is also covered under Medicare.

Medicare does not pay for the examination for or purchase of a hearing aid. Artificial legs, arms and eyes also are covered by Medicare when furnished under a physician's order. Stump stockings and harnesses, including their replacements, are also covered if they are necessary for the effective use of the artificial device.

Note: If you or your office assistant have any questions regarding Medicare, they may be directed to Mr. Richard Quigley, Special Representative, Professional Relations Department, Illinois Blue Shield, 222 North Dearborn.

(This is not an advertisement)

The president's page



Philip G. Thomsen, M.D.

Unity Begins with the Counties

The medical profession has lost much of its impetus since World War II . . . is less able to resist assaults on its freedom, preserve its image and influence, plan its future.

Yet we need more strength than ever before, because the attack on our profession—from Big Government, Big Welfare, Big Labor—has gained impetus.

Why has our strength slipped?

To find one of the chief reasons, let's dip into history.

There was a time when county medical societies were the pivotal forces in local medical affairs.

While some are notably hale, hearty and well-organized, many of the county societies in our state have withered. They cannot rally enough membership support to have functioning committees, ambitious programs, fruitful meetings.

A key reason for this decay is that physicians have diverted their time and attention to their specialty groups. The first American specialty board was incorporated during World War I, but the real upsurge came with World War II.

Even in hospitals, the general staff conference has largely been superseded by meetings of specialized departments.

No one should belittle the growth of medical skills, and their refinement. But overconcentration on specialties—especially at the local and county level—segments and divides our medical house.

We need the general unity which only the all-inclusive medical societies can give us.

We need such unity if we are to prevail on the key socio-economic, legislative and political issues of our day . . . if we are to check the inroads of government, corporate practice and quasi-medical groups . . . if we are to preserve our stature and dignity as private physicians.

Only in unison can we make Springfield listen to us on such impending legislative issues as abortion, drugs, medical education, state revenue, community health, a proposed Medical Review Board to weed out unsafe drivers.

Only together—not just as anesthesiologists, radiologists or surgeons—can we achieve real adjustments in physicians' fees under public-aid programs.

ISMS wants to deal zealously with these issues—but the strength of your State Society rests, in large measure, on the strength of the county societies. Our efforts will bear fruit only if they are nourished at the roots. And I've been saying so on our President's Tours up and down the state.

Local businessmen—whether merchants or foundry managers—have their vigorous chambers of commerce. Labor-union locals, whether bricklayers or teachers, are joined in community federations.

So, my fellow physicians, let us not be a Tower of Babel, speaking the languages of different specialties. Let us unite from the county to the state and AMA levels, and be a Tower of Strength.

Philip G. Thomsen M.D.

Meeting Memos

Dec. 26-31—The American Association for the Advancement of Science will hold its 135th meeting in Dallas, Texas. Over 95 symposia will be featured on the program, along with 1,200 speakers reporting recent developments in all branches of science.

Jan. 9-12, 1969—The Sixth Annual Postgraduate Seminar in Anesthesiology will be presented by the University of Miami and the University of Florida in Miami Beach. The program is being sponsored by the American Society of Anesthesiologists.

Jan. 12-17—The recently formed Society for Cryosurgery will hold its annual meeting in Miami Beach, Florida. New advancements in the field will be discussed and papers concerning recent developments will be presented.

Jan. 20-21—The Cleveland Clinic Educational Foundation will present a postgraduate course in "Cardiovascular and Renal Clinical Pharmacology." The registration fee is $40.00 and should be sent to: Education Secretary, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

Jan. 24-26—The Seventh Clinical Conference in Pediatric Anesthesiology will be presented by Childrens' Hospital of Los Angeles in L.A., under the guidance of the American Society of Anesthesiologists.

The paradox of the smoking habit, society's acceptance and promotion of it, and medical science's classification of it as being a health hazard, is shown in a 20½-minute black and white film entitled "Getting Through." Intended for teenagers as well as young adults, in this film Burt Lancaster presents some of the troublesome questions about cigarette smoking. The film dramatizes the "smokey" world in which teenagers live, and concludes that the final decision about smoking is ultimately a personal decision which each teenager must make after carefully weighing the facts. Teachers, youth workers, and parents will be most interested in this film as well as health-centered personnel. It is available for free short-term loan from National Medical Audiovisual Center (Annex), Chamblee, Ga., 30005, Attention: Film Distribution Department. It may be purchased from DuArt Film Laboratories, 245 W. 55th St., New York 10019.

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Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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Abstracts of Board Actions

Meeting October 5, 1968—Springfield

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

NEW ADVISORY COMMITTEE ESTABLISHED

An ISMS Advisory Committee to the Department of Vocational Rehabilitation, to be established separate from the existing DVR Medical Committee, since the latter committee has little or no direct contact with the ISMS, was proposed. It was resolved that negotiations should proceed with Mr. Slicer, DVR director, on the establishment of this Advisory Committee separate and apart from the ISMS Committee on Rehabilitation Services.

JOINT CONFERENCE WITH NURSES TO BE HELD

The Executive Committee, in reviewing activity of the Nursing Committee of the Illinois Nurses Association with relation to the Statement on Acute Cardiac Care, felt that a joint conference was desirable before final approval was given, and that the services of legal counsel should also be utilized. A joint conference including representatives from ISMS, the Illinois Hospital Association, the Illinois Nurses Association and the Illinois and Chicago Heart Associations, with legal counsel present was recommended. Dr. Taylor, chairman of the ISMS Committee on Nursing, indicated that he intends to meet with the representatives of the Nurses Association and the other groups involved and will take advantage of the knowledge of legal counsel to establish something definitive. He also stressed that there could not be, over the State of Illinois, uniform rules and regulations for every hospital; local institutions must be allowed some flexibility in their operations. It was recommended that a joint conference be held with final approval of decisions to come at the January Board.

CHICAGO MEDICAL SOCIETY ASKED TO HELP WITH HEALTH CENTER

The Community Interest Committee of Southwest Lawndale (Chicago) requested ISMS assistance in the establishment of a neighborhood health center without government support. Following a discussion as to the ramifications of such a project, the Board referred this matter to the Chicago Medical Society.

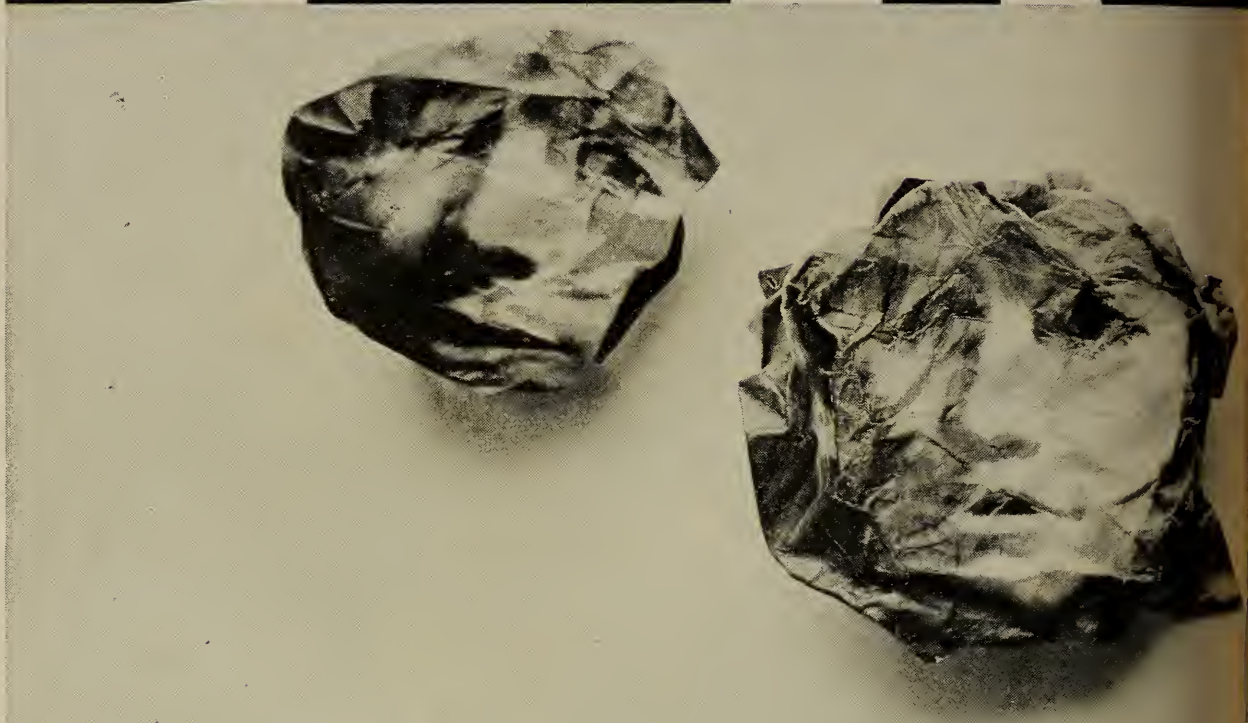
HEALTH INSURANCE PLAN SUPPORTED

Dr. W. Randolph Tucker, medical director, Presbyterian-St. Luke's Health Centers, presented a plan regarding the development of a program of health insurance for residents in the Chicago west side area. He requested ISMS cooperation. Following a description of the proposed plan, the Board voted endorsement in principle and requested progress reports.

(Abstracts continued on page 806)

early relief from

DEPR



At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves... mood fluctuations lessen... sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type...any degree of severity.

LAKESIDE

IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, dizziness, palpitation, delayed urination, agitation and stimulation ("jumpiness," "nervousness," "anxiety," "insomnia") bad taste, sensory illusion, tinnitus, sweating, drowsiness, headache, hypotension (orthostatic), flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy (general), altered liver function, ataxia and extrapyramidal signs, agranulocytosis.

Additional side effects more recently reported include: seizures, eosinophilia, confusional states with hallucinations, purpura, photosensitivity, galactorrhea, gynecomastia, and impotence. Side effects which could occur (analogy to related drugs) include weight gain, heartburn, anorexia, and hand and arm paresthesias.

DOSAGE: Optimal results are obtained at a dosage of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1,000; and tablets of 50 mg. in bottles of 30, 250, and 1,000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

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February 16-18, 1969

Sheraton Park Hotel

Washington, D.C.

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Be There . . . On Sunday, Feb. 16 when ISMS officials and fellow Illinois physicians meet with Illinois Congressmen and learn what's ahead in this crucial post-election year.

Join . . . U.S. Chamber of Commerce members on Feb. 17-18 as they too survey the legislative prospects, hear fascinating speakers and become better informed citizens and professionals.

Don't Delay! Register Now!
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ON THE COVER

In this season of festivity, we wish for each of our readers a Happy Holiday Season and our hopes for a Prosperous New Year.

A few observations about various customs of the season may be of interest.

The next time someone gets bussed under the mistletoe you may want to inform the "Busser" that years ago mistletoe was used as a charm to ward off witches and thunder. If you keep your Yule log lit throughout the night, that's good luck. But be careful if a squinting person comes in while it's burning. An ill omen.

On New Year's Eve, a ball is dropped in Times Square as the midnight hour approaches. In Japan bells gong 108 times. Italians hurl glasses out the window, while Scots walk through the streets carrying a barrel of tar. In Geneva every piece of available artillery is fired. The French visit all their friends on New Year's Day to inform them that a new year has arrived while the Mexicans celebrate with a festive fiesta.

Called "noels" in France, "le pastorali" in Italy and "weinichwiesl" in Germany, Christmas Carols have a noteworthy history. The earliest consisted of gloomy music rather than happy sounds. Before Carols were sung they were danced.

Again, best wishes for a Joyful Holiday Season.

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

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Intensive Cardiac Care

Two Years Experience

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On January 5, 1965, Louis A. Weiss Memorial Hospital opened a fifteen bed monitored Intensive Cardiac Care Unit. A full time Medical Director supervised the unit. Review of the literature indicated the need for cardiac monitoring in all patients with severe sustained angina pectoris regardless of the absence of electrocardiogram abnormalities.

The nurse-patient ratio was 1:3 with additional nursing aide and secretarial help. A resident physician was assigned to the unit for 24 hours. The nurses selected for I.C.C.U. received 80 hours of lectures on cardiac physiology, therapy, and ECG interpretation. Admissions and transfers were approved by the director of the unit. Patient visiting was limited to five minutes on the hour around the clock.

Initial efforts were directed toward the treatment of cardiac arrest; later experience related more to the prevention of cardiac arrest, particularly the immediate treatment of ectopic ventricular beats, early heart failure, and incipient cardiogenic shock.

Selection of Patients

All patients with severe or sustained angina were admitted to I.C.C.U. Patients with old myocardial infarctions having sustained angina, syncope, or pulmonary edema were also admitted. Frequently, such patients' electrocardiograms showed no change from previous tracings except for the presence of ectopic ventricular complexes. Other patients admitted had either arrhythmia or heart block.

The I.C.C.U data included all patients treated in the emergency room for either cardiac arrest or severe cardiogenic shock and pulmonary edema, as all such patients were admitted to I.C.C.U.

Table I

MORTALITY
FROM MYOCARDIAL INFARCTION
LOUIS A WEISS MEMORIAL HOSPITAL

	1963-64 General Care	1965-66 I.C.C.U.	1966-67 I.C.C.U.
Total Patients admitted with M.I.	213	241	311
Total Deaths*	65	60	48
Mortality Rate	30.5%	25%	15.4%

*All patients admitted to I.C.C.U., including moribund patients with pulmonary edema and cardiogenic shock, expiring any time after admission from the emergency room or general hospital.

Physical Examination

The patient with severe coronary insufficiency or myocardial infarction often exhibited cool, moist skin, pallor, and a rapid, weakened pulse. He frequently had a palpable apical cardiac impulse, and a fourth heart sound of atrial systole with presystolic ventricular filling sound heard late in the diastolic period. Less frequently, a third heart sound of early ventricular filling was heard at the apex suggesting left ventricular insufficiency. Reduced intensity of the first heart sound was common.

Treatment

On arrival at the unit, the patient was immediately monitored and an intravenous needle inserted either as a glucose-potassium infusion or with a heparin adapter. Every effort was made to reduce the patient's anxiety and discomfort. Patients with suspect infarction were monitored three to five days, and patients with definite infarction were monitored seven to ten days. Most authorities have agreed on a minimum of seven days monitoring for patients with myocardial infarction. We have experienced unexpected deaths after transfer from I.C.C.U. indicating the need for longer periods of monitoring. Proper selection of electrodes reduced false alarms and caused a minimum of skin irritation. Floating electrodes and silver-silver chloride electrodes were well tolerated as were short 23 gauge stainless steel needles. Patients with complications had central venous pressure monitoring and fluid infusion with additional access to an arm vein through an intravenous needle or cut down with a plastic catheter. Five percent glucose with 40 meq. KCl was infused; saline solutions were avoided in acute cardiac patients. True hyponatremia, not dilutional as in congestive heart failure, was treated with 100 cc. infusions of 5% NaCl. Occasional patients developed hypotension after vigorous diuretic therapy due to volume depletion and received fluid volume restoration with central venous pressure monitoring. KCl therapy was avoided in patients with second or third degree heart block and in patients with cardiogenic shock unless hypokalemic. Oxygen therapy was given for two to three days with careful monitoring of vital signs for undesirable physiological effects of 0_2 therapy. Arterial oxygen, carbon dioxide, and pH values were obtained in patients with cardiogenic shock and pulmonary edema. Serum potassium was determined on admission of all patients. Most patients received an admission portable chest x-ray to evaluate the presence of hilar vascular congestion.

The smallest effective doses of opiates were used for the relief of pain, and repeated only as needed because of the frequent development of hypotension, sinus bradycardia and varying degrees of A-V block when large doses of opiates were administered. Such undesirable effects were treated with 0.5 to 1 mg. of I.V. atropine, and 1 mg. isoproterenol in 1 liter of 5% dextrose in distilled water; hypotension was treated with central venous pressure monitoring and volume expansion if the CVP was below 10 cm. Vasopressor therapy was instituted when the hypotension was associated with oliguria and other approaches ineffective.

Sedatives and tranquilizers were given in reduced dosage until their effects on physiological parameters were observed. Catecholamine depleting drugs were avoided. Synergism between sedatives, tranquilizers, and opiates was observed.

All patients were placed on a liquid low salt diet for two to three days after admission when the possibility of cardiac arrest was greatest. Careful attention was given to the patient's excretory functions to avoid distention of the urinary bladder or rectal ampulla, and possible reflex vagal cardiac effects. Foley catheters were necessary in some patients and were always inserted in patients with cardiogenic shock. Most patients were allowed the use of a bedside commode with an aide or nurse present and monitoring continued.

Treatment of Complications

We have observed our patients with left ventricular insufficiency and pulmonary edema as:

a) Patients with mild pulmonary edema and normal blood pressure;

b) Patients with massive foaming pulmonary edema and hypertension;

c) Patients with massive pulmonary edema and severe cardiogenic shock.

The first two types of patients were treated with 10 mg. of morphine sulfate, tourniquets, and intravenous ethacrynic acid or furosemide 50 to 100 mg. The patients with severe pulmonary edema were venesected 300-500 cc.'s of blood immediately on arrival to the emergency room or while on the I.C.C.U. Patients not on maintenance digitalis preparations were given 0.4 mg. cedilanid intravenously with careful monitoring for ventricular ectopic rhythms and atrio-ventricular blocks before additional amounts were given. It has been our policy not to push digitalis preparations in patients with myocardial infarctions hoping to gain an inotropic response with less than complete doses. Short acting preparations were used. Lidocaine was effective in many atrial arrhythmias as well as those of ventricular origin. Positive pressure ventilation was beneficial in those patients who tolerated the mask. Large doses of intravenous hydrocortisone, 500 mg. to 1 Gm., were given to treat severe bronchospasm. The patients with foaming pulmonary edema and no obtainable blood pressure gave us our highest mortality in patients with acute myocardial infarction and seldom responded to vasopressor therapy.

Arrhythmias

Ectopic ventricular complexes have been treated with the immediate intravenous injection of 50 mg. of 2% Lidocaine every three to five minutes for three to four doses, and 1 to 2 Gms. of Lidocaine added to 1 liter of 5% Dextrose solution to run at 10 to 15 drops a minute. When Lidocaine was ineffective in eliminating frequent or coupled premature ventricular contractions, 100 mg. of procaine amide was injected intravenously every two to three minutes up to 0.5 or 1 Gm. Subsequent treatment with 1 to 2 Gms. of procaine amide in 1 liter of glucose solution was given as an intravenous drip. Lidocaine did not cause hypotension or seizures in our patients.

Table II

MORTALITY
FROM MYOCARDIAL INFARCTION
PULMONARY EDEMA AND CARDIOGENIC SHOCK

Patients with Pulmonary Edema and Cardiogenic Shock	1963-64 General Care	1965-66 I.C.C.U.	1966-67 I.C.C.U.
	39	50	56
Deaths	30	36	38
Mortality Rate	77%	72%	69%
Expired under 1 hour		8	7
Expired 1-24 hours		8	10

We have not routinely given patients antiarrhythmic drugs on admission to the unit and have preferred Lidocaine as a less depressant antiarrhythmic drug. Tachycardias possibly digitalis induced were treated with intravenous injections of 0.1 to 0.5 mg. propranolol every five to ten minutes up to 3 to 4 mg. observing for excessive slowing of the pacemaker and pulmonary edema. In patients with myocardial infarction we have observed extreme sinus bradycardia and periods of pacemaker arrest during intravenous propranolol injection necessitating resuscitation and isoproterenol. Brief periods of unilateral carotid sinus pressure of four to five seconds has allowed recognition of "p" or flutter waves in some patients. Either supraventricular or ventricular tachycardias were treated with oxygen and metaraminol when the patients with myocardial infarction were hypotensive. If the tachycardia persisted and the non-digitalized patient experienced

severe pain or pulmonary edema, we elected direct current countershock as the safest procedure and most effective for terminating the tachycardia. Following countershock, appropriate antiarrhythmic drugs were maintained for several weeks. Supraventricular tachycardia's in non-digitalized patients with myocardial infarction were treated initially with cedilanid 0.4 mg. intravenously up to 1.0 mg. Digitalized patients needing emergency countershock were given intravenous Lidocaine or procaine amide and an intravenous glucose-potassium infusion prior to countershock. Recently we have also used 0.1 to 0.5 mg. intravenous injections of propranolol up to 3 mg. at three to five minute intervals.

Sinus tachycardia has proved difficult to treat in patients with extensive infarction even though digitalized and with normal electrolytes, blood volumes, and central venous pressures. Sinus bradycardia was treated with intravenous atropine and an infusion of 1 mg. isoproterenol in a liter of glucose solution. When such patients were hypotensive, either metaraminol or levarterenol was given in slow intravenous drip. Patients with posterior or inferior infarction responded to conservative therapy although a transvenous pacemaker was inserted in patients with oliguria and hypotension. We used similar treatment for patients with inferior infarction who developed second or third degree heart block, and inserted a transvenous pacemaker when unsuccessful or when ventricular tachycardia resulted from isoproterenol stimulation. Digitalis and antiarrhythmic drugs were not given to patients with sinus bradycardia or heart block unless a pacemaker was functioning. Most patients having Stokes-Adams episodes were paced.

Table III

DEATHS AFTER TRANSFER FROM I.C.C.U.

1965 - 1966		1966 - 1967	
Days on I.C.C.U.	Day of Death after transfer	Days on I.C.C.U.	Day of Death after Transfer
3	16	6	6
3	6	6	5
3	6	8	5
6	7	8	21
10	7 months	9	21
10	7	14	4
30	4	14	7

Cardiogenic Shock

Our greatest mortality was in patients with severe cardiogenic shock. We observed three main clinical types of patients with acute myocardial infarction and cardiogenic shock: 1) patients with cool, wet skin, hypotension, pallor, experiencing chest pain at the time of admission but not pressor dependent; 2) patients with severe cardiogenic shock, oliguria, moderate pulmonary edema who were pressor dependent; 3) patients with severe cardiogenic shock and massive foaming pulmonary edema, unresponsive to pressor drugs and other treatment. The highest mortality was in patients with massive pulmonary edema and no recordable blood pressure or femoral pulse, not responding to levarterenol during constant monitoring.

All patients in shock had central venous pressure catheters inserted and were volume expanded if central pressures were below 10 cm. water, and were given 0.8 mg. of cedilanid in divided doses if the central venous pressure was above 15 cms. Aramine or levophed was infused after volume expansion if hypotension persisted with oliguria; sodium bicarbonate and antiarrhythmic drugs were used as indicated. Isoproterenol was only given in glucose solution if bradycardia or partial A-V block was associated with shock. When oliguria persisted during pressor therapy with systolic arterial pressure of 100 to 110 mm. Hg., 40 mg. phentolamine was added to the glucose infusion of 15 to 20 drops per minute. This therapy resulted in diuresis and warming of the skin in recent patients treated.

Cardiac Arrest

Most patients expiring with unsuccessfully treated cardiogenic shock and pulmonary edema demonstrated acidotic rhythms with descending pacemakers and final slow wide bizarre ventricular complexes terminating in asystole. Resuscitation in these patients was invariably unsuccessful. Sudden ventricular fibrillation was not observed unexpectedly when premature ventricular beats were treated by intravenous Lidocaine, followed by Lidocaine or pronestyl slow intravenous drip infusion. Patients with end-stage hearts, marked cardiomegaly, refractory heart failure, and azotemia were unsuccessfully resuscitated and in general had

complications and were not unexpected cardiac arrests. Techniques of resuscitation were standard with immediate thumping of the chest, external cardiac massage and resuscitube or bag ventilation. Defibrillation was done in the shortest possible time with no delay, and not interrupting massage for any procedure, such as endotracheal intubation. Rapid resuscitation with restoration of a normal sinus rhythm usually resulted in a conscious or semi-stuporous patient with spontaneous respiration and blood pressure. Comatose patients were intubated until recovering consciousness. Defibrillation was done with 300-400 Joules or Watt/seconds, 0.5 Gm. procaine amide was injected directly I.V., and 2 Gms. added to glucose infusion as slow drip; 88 meq. of sodium bicarbonate was injected every five minutes, and levophed infused as needed. Most of our successful resuscitations have followed defibrillation done within one to two minutes after onset of ventricular fibrillation.

Asystole was treated with cardiopulmonary resuscitation and intravenous injections of 0.5 mg. epinephrine repeated at two to three minute intervals. Ventricular fibrillation which at times followed was then countershocked. Fewer successful resuscitations resulted when the arrest was due to asystole.

Summary

Intensive cardiac care of high risk patients reduces mortality from ischemic heart disease, and allows for early detection and management of complications. Unexpected cardiac arrest in monitored patients should seldom occur. Patients with advanced heard disease and severe cardiogenic shock have the greatest mortality.

This review offers the authors' current approach to the daily problems encountered on the cardiac care unit, recognizing the need for individual patient management, and the unpredictibility of patient responses to therapy during acute ischemic episodes.

References

1. Baroldi, G.: Myocardial infarction and sudden coronary heart death in relation to coronary occlusion and collateral circulation. Am. Ht. J., 71:6, (June, 1966) 826-836.
2. Bessinger, H.: Physiology of the normal and ischemic heart. Hosp. Topics, 44:11, (Nov., 1966) 44-48.
3. Day, H., and Averill, K.: Recorded arrhythmias in an acute coronary care area. Diseases of the Chest, 49:2, (Feb., 1966) 113-118.
4. Day, H.: Unit increases patients' chances of survival after cardiac arrest. Hosp. Topics, 44:11, (Nov., 1966) 20-22.
5. Gunnar, R., et al.: Myocardial infarction with shock: hemodynamic studies and results of therapy. Circ. 33 (May, 1966) 753-762.
6. Killip, T., III, and Kimball, J.T.: Treatment of myocardial infarction in a coronary care unit. Am. J. Card., 20:4, (Oct., 1967) 457-464.
7. Lown, B.: Coronary care unit: new perspectives and directions. JAMA, 199:3, (Jan. 16, 1967) 188-198.
8. Meltzer, L., and Kitchell, J.: Incidence of arrhythmias associated with acute myocardial infarction. Progress in C.V.D., 9:1, (July, 1966) 50-63.
9. Nachlas, M. et al.: Observations on defibrillators, defibrillation and synchronized countershock. Progress in C.V.D., 9:1, (July, 1966) 64-89.
10. Progress in Cardiovascular Diseases: Acute Myocardial Infarction and Coronary Care Units—I, II, & III, 10:5, 10:6, 11:1 (March, May, & July, 1968.)
11. Shubin, H., and Weil, M.: Treatment of shock complicating acute myocardial infarction. Progress in C.V.D., 10:1, (July, 1967) 30-54.
12. Silver, J.: Anatomy and physiology of a cardiac care unit. Bull. of Louis A. Weiss Mem. Hosp. (Chicago,) Spring, 1966, Vol. 7, 13-31.
13. Surawicz, B.: *Sudden Cardiac Death,* Grune & Stratton, New York, N.Y., 1964.

Stretch Garment Dermatitis

A disease of the skin, not hitherto described, is caused by pressure or tension on the skin from the wearing of tight-fitting stretch garments such as "stretch bras," "stretch girdles" and "stretch socks." The condition is not due to chemical sensitization of fabrics, dyes or other additives but is of mechanical origin.

The eruption may assume various clinical forms and may be characterized by a nondescript erythematous and eczematous appearance or may consist of an exaggeration, in the areas covered by the stretch garment, of already existing dermatosis such as lichen planus, psoriasis, acne vulgaris, discoid lupus erythematosus or atopic dermatitis. (Richard Mihan and Sameul Ayres, Jr., "Stretch Garment Dermatitis"; **Calif. Med.** [Feb.] 1968; **108**:2; pgs. 109-112.)

Simultaneous Adenocarcinoma Of The Esophagus And Stomach

By Bernard Peison, M.D./Chicago

Although simultaneous primary malignancies of the colon and rectum as well as the respiratory tract are not uncommon, few reports have dealt with multiple primary tumors of the upper gastrointestinal tract.

This report concerns the pathological findings of simultaneous adenocarcinoma of the esophagus and stomach. The case, at autopsy, revealed an extensive and widespread adenocarcinoma of the esophagus. The tumor originated from the mucosal esophageal glands rather than from displaced or heterotopic gastric glands as has been reported by other authors[1-3]. There was, in addition, a second independent adenocarcinoma in the cardiac portion of the stomach. The case had a radiological diagnosis of esophageal hiatal hernia. Its association with esophageal carcinoma will be discussed.

The purpose of this paper is to alert the pathologist and clinician of the possible coexistence of two independent primary glandular tumors at the cardio-esophageal junction, so that a masked adenocarcinoma of the gastric cardia is not overlooked. That adenocarcinoma of the esophagus is a distinct clinical and pathological entity, which may originate from esophageal mucosal glands at any level. Because of its intramural submucosal location, the tumor may produce negative roentgenographic and fundoscopic findings or mimic a benign lesion.



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Report of a Case

A forty-two year old man entered Mercy Hospital complaining of peri-umbilical pain for approximately two months. The patient noted black stools and he vomited blood on one occasion. There was a 15 pound weight loss since the onset of his illness.

Physical examination revealed a thin adult man in no distress. The blood pressure was 130/90 mm Hg; the pulse was 82 per minute; and the temperature 98.6°F. The heart and lungs were normal.

A chest film revealed a metastatic lesion on the right sixth rib. Upper gastro-intestinal films demonstrated a fixed hiatal hernia. Proctoscopy and esophagoscopy were negative. The patient had a protracted downhill course and expired 61 days following admission.



Fig. 1. **Gastroesophageal junction with neoplasm involving the lower end of the esophagus and portions of the cardia.**

Post mortem examination showed an extensive ulcerated tumor involving the mid-



Fig. 2. **Esophageal mucosa with neoplastic transformation of cardiac or superficial esophageal glands. Hematoxylin and eosin stain, x 150.**

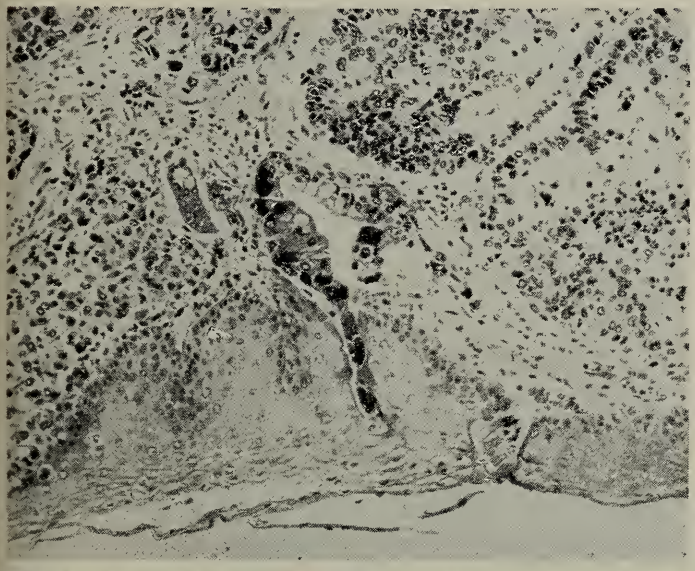


Fig. 3. **Esophageal mucosa with neoplastic mucosal glands. Hematoxylin and eosin stain, x 150.**



Fig. 4. **Neoplastic transformation of cardiac esophageal glands. Note nests of tumor cells in the left upper corner. Hematoxylin and eosin stain, x 150.**

dle and lower third of the esophagus and extending into the cardiac portion of the stomach (Fig. 1). The tumor appeared to encircle the entire circumference of the esophagus and measured six by four cms. There were metastases in the lymph nodes, lungs, adrenal glands, liver, pancreas, right sixth rib and fourth thoracic vertebra. Histological examination revealed the entire esophagus involved with a neoplasm arising from the esophageal mucosal glands (Figs. 2, 3, 4). The tumor displayed a glandular pattern with areas of squamous metaplasia. In other areas the pattern was completely undifferentiated (Fig. 5). There were large areas of necrosis and massive lymphatic and vascular permeation (Fig. 6) .

Mucicarmine stain showed small amounts of mucin in an occasional neoplastic acini. There was another independent primary neoplasm in the gastric cardia, arising distinctly from the gastric mucosa. The tumor was a mucin producing adenocarcinoma which extended into the muscularis (Fig. 7). In some areas, there was an admixture of both types of tumor cells, due to the invasion of the gastric wall by the esophageal neoplasm (Fig. 8). Tumor cells from the stomach were not identified in the esophagus. The esophageal squamous epithelium was thinned but not ulcerated. The cardio-esophageal junction showed no direct continuity between both neoplasms.

Discussion

The coexistence of two primary neoplasms at the esophago-gastric junction is extremely rare. On reviewing the literature only two similar reports were found. Mingh and Bullough[4] reported a preinvasive papillary adenocarcinoma of the esophagus accompanied by an invasion poorly differentiated adenocarcinoma at the cardia of the stomach. Dodge[5] reported a collision tumor, where a gastric adenocarcinoma and an esophageal anaplastic carcinoma had grown together to form a single tumor mass. Adenocarcinoma of the esophagogastric junction has merited extensive consideration in the surgical literature because of its insidious behavior and ominous prognosis. Adenocarcinoma of the esophagogastric junction is characteristically associated with a greater degree of submucosal invasion of the esophagus than the squamous

cell variety. Distant metastases tends to occur earlier than with the squamous tumor[6].

Although there are inherent difficulties in any attempt to demonstrate the existence of two primary independent foci of neoplasia, the tumors in the case being presented were clearly of separate origin. The sharp demarcation of each tumor and the striking differences in histological patterns tend to establish these neoplasms as separate primaries.

Carcinoma of the esophagus constitutes approximately five per cent of all visceral carcinomas[7]. Most of the tumors are of squamous epithelial type with a small percentage being definitely glandular. The origin of malignant glandular tumors arising in the esophagus remains controversial. It has been stated[8] that all adenocarcinomas at the cardia are derived from either normally situated or heterotopic gastric glands, or from an epithelium capable of differentiating into both glandular and squamous epithelium, thus forming an "adenoacanthoma." An inconstant finding is the presence of patches, usually small, of gastric mucosa replacing portions of the lining squamous epithelium. Rector and Connerly[9] found it to be 7.8 per cent in a series of 1,000 infants and children. They found such glandular patches to be more common in the upper than in the lower esophagus. Rector and Connerly[9] regard gastric patches in the esophagus to be due to an embryological displacement during the descent of the stomach. Willis[10] believes, on the contrary, that it is an example of heteroplasia, observing that the embryonic endoderm from the upper esophageal to the mid-colonic level is able to form gastric mucosa by heteroplastic differentiation. Finally one must consider the comparatively rare esophageal anomaly in which a variable length of the esophagus is lined by glandular epithelium of cardiac type, which is in continuity at its lower

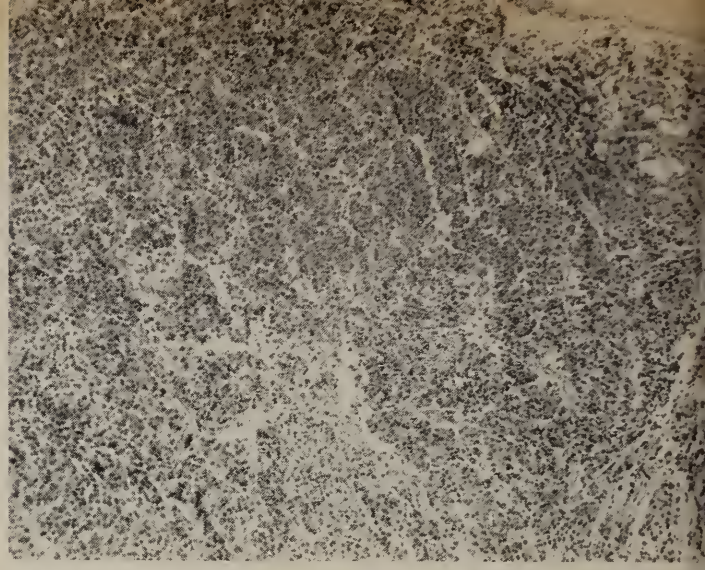


Fig. 5. **Portion of tumor where the cells are less differentiated. Note the intact thinned squamous mucosa. Hematoxylin and eosin stain, x 60.**

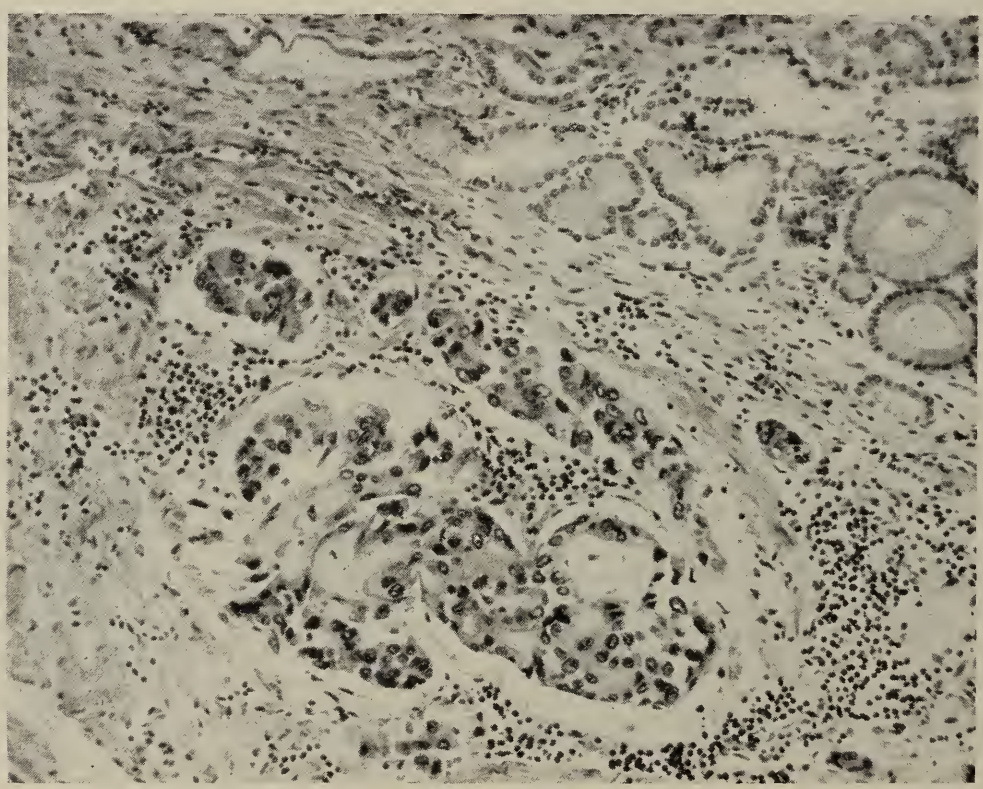


Fig. 6. **Nests of esophageal carcinoma in gastric lymphatic. Note the mucoepidermoid character of the tumor cells. Mucicarmine stain, x 150.**

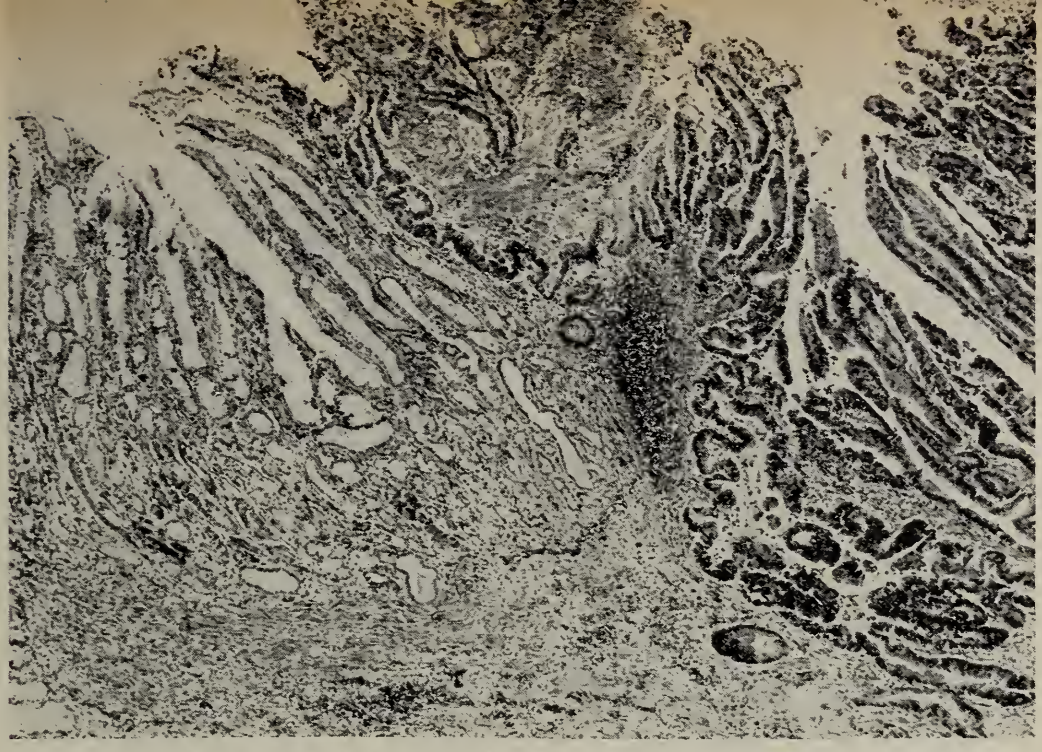


Fig. 7. **Adenocarcinoma arising from the gastric cardia. Hematoxylin and eosin, x 30.**

level with the glandular epithelium of the stomach[11]. This condition is termed Barrett esophagus by some authors. Others believe that the term more accurately describes an acquired condition following ulcerative esophagitis in a patient with hiatal hernia.

Rare Type

Primary adenocarcinoma of the esophagus is rare, being encountered less often than the squamous cell type. It usually involves the lower third of the organ, where it is not always possible to differentiate the lesion from a primary tumor in the stomach. It is estimated that primary adenocarcinoma of the esophagus comprises approximately eight to ten percent of the primary esophageal tumors[12]. The exact origin of the tumor in many of the cases reported has been largely speculative because the lesion was in an advanced state of development at the time of examination. While some authors admit that adenocarcinoma may arise in the esophageal glands, most[12-14] of the reports infer an origin from ectopic gastric glands in the esophagus.[1-3] Raphael, et al,[14] reviewed the records of 1,312 patients seen at the Mayo Clinic from Jan. 1946 through Dec. 1963 who had a diagnosis of primary adenocarcinoma of the esophagus. They found only ten to fulfill the criteria as true examples of primary esophageal adenocarcinoma. According to Azzopardi and Menzies[12] the existence of adenoid cystic tumors of the esophagus constitute incontrovertible evidence of the existence of primary esophageal adenocarcinoma, since the issue is not obscured here by the question of secondary spread from the stomach, the possibility of a thoracic stomach, or an origin from the junctional epithelium.

In the case object of this study, the esophagus was extensively infiltrated by nests of tumor cells which were distinctly seen arising from the superficial mucosal glands as demonstrated in Figs. 2, 3 and 4. The overlying squamous mucosa was intact and present throughout its entire extension, although it was markedly attenuated by compression of the underlying tumor. One can exclude therefore the existence of a patch of gastric mucosa or a Barrett type of esophagus, from where the tumor cells could conceivably have arisen. Submucosal spread was extensive and associated with vascular and perineural lymphatic invasion. The tumor cells displayed a glandular pattern with areas of squamous metaplasia, giving a pattern of the so called "adenoacanthoma." Small amounts of mucin were present in some of the neoplastic acini. In other areas the tumor cells were completely undifferentiated and arranged in large sheets.

In the cardiac portion of the stomach there was another primary tumor (Fig. 7). The gastric tumor cells were seen arising by gradual transition from the gastric mucosa. They were arranged in well defined glandular acini and the lumina contained large amounts of mucin as demonstrated by the mucicarmine and PAS stains. Although it is stated that most adenocarcinomas of the lower end of the esophagus represent

an upward extension from a primary tumor in the stomach,[8] when tumors of this histological type involve the esophagus at higher levels there is no option but to regard them as primary esophageal neoplasms. The gastric adenocarcinoma was seen infiltrating the muscularis, and in a few areas the gastric and esophageal tumor cells were intermingled. At no time was there direct microscopal continuity between the gastric and esophageal tumors. Neoplastic cells from the stomach were not identified in the esophagus, with numerous nests of esophageal neoplastic cells within the gastric wall and lymphatics. It may be argued that because of the widespread lymphatic permeation, the gastric lesion may well have been metastatic or viceversa.

The distinct origin of the neoplasms from the cardiac esophageal glands and gastric mucosa will clearly demonstrate that the tumors are of separate origin. Distant metastases in the rest of the organs were primarily from the esophageal neoplasm as evidenced by their mucoepidermoid character. Stout, et al[8], states that no true case of metastasizing esophageal adenocarcinoma has been reported. This case demonstrates that true adenocarcinoma of the esophagus may become extremely aggressive and metastasize. Raphael, et al,[14] in their series, reached similar conclusions.

Attempt to Explain Origins

Smithers[15] postulated that there are three possible origins of true adenocarcinoma of the esophagus as distinguished from primary gastric carcinomas: carcinoma arising in ectopic islets of gastric mucosa; in esophageal mucous secreting glands; in esophageal mucous membrane which have failed to undergo squamous transformation before birth. Primary intraesophageal adenocarcinoma probably arises either from superficial cardiac glands, from deep glands, or from a columnar type of epithelium.

Of great interest was the presence of an esophageal hiatal hernia. Many authors have been impressed with the frequency with which carcinoma of the gastric cardia and associated hiatal hernia are encountered. Esophageal hiatal hernia is extremely common, particularly in middle aged and elderly persons, in whom there is also a relatively high incidence of carcinoma. It becomes apparent that the incidence of carcinoma under these circumstances is higher

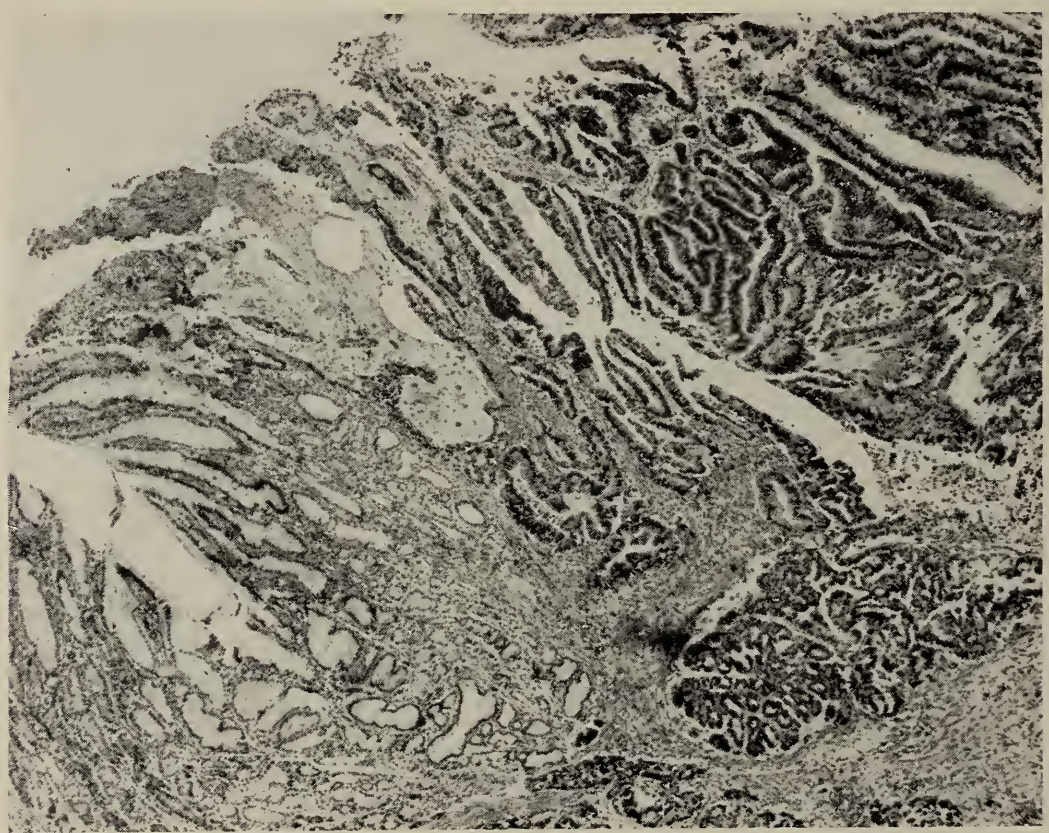


Fig. 8. **Gastric adenocarcinoma arising from normal adjacent mucosa. Note in the lower corner, nests of tumor cells from the esophagus. Mucicarmine stain, x 30.**

than coincidence alone would permit. Groves and Effler[16] found 12 cases during a period of approximately 12 years, in which more than 500 patients were surgically treated for esophageal hiatal hernia. All of the neoplasms in these 12 patients were adenocarcinomas. They postulated that chronic gastritis attendant to the long standing reflux esophagitis may well predispose to adenocarcinoma associated with hiatal hernia. According to Smithers [17] the two most common factors responsible for the association of adenocarcinoma of the esophagus and hiatal hernias would seem to be: that a small lower portion of the esophagus is frequently lined by glandular epithelium which, at this constricted site, is particularly liable to malignant disease, and that there is preferential spread in the submucous lymphatics of the esophagus by tumors arising at the cardia. As both these tumor types develop in the hiatal tunnel, they tend to cause dilation and produce irritation, both of which predispose to herniation.

The unusual opportunity afforded by the numerous tissue sections obtained in the case made possible the identification of the two independent primary neoplasms at the cardio-esophageal junction. Although it is indeed difficult to establish double primaries in organs with similar histological features, it is believed that this can be established in the case studied, based in the origin and different histological features of both tumors and in the asyncrony and different invasive characteristics.

Summary

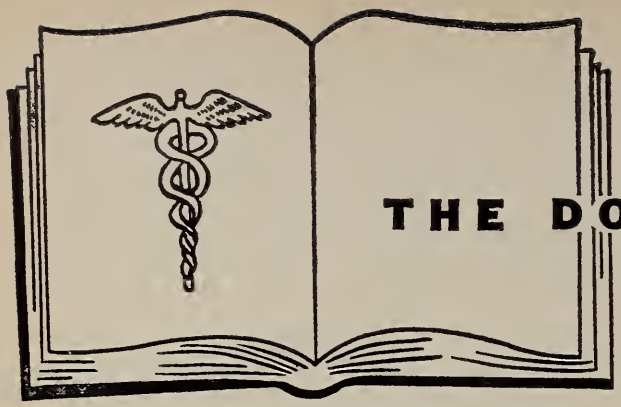
A case of primary independent adenocarcinoma involving the esophagus and gastric cardia is documented. Histological evidence is presented to show that primary esophageal adenocarcinoma may arise from the superficial esophageal glands at any level. Because of its extraluminal and yet entirely intramural location, the esophageal tumor may produce negative roentgenographic and fundoscopic findings.

The association of adenocarcinoma of the esophagus and gastric cardia with esophageal hiatal hernia is demonstrated. It is suggested that the reflux esophagitis and or chronic irritation, may not only predispose to adenocarcinoma of the esophagus but also of the gastric cardia. It is recomended that multiple sections be taken in such instances, so that a masked carcinoma of the gastric cardia is not overlooked.

References

1. Armstrong, R. A., Blalock, J. B. and Carrera, G. M. Adenocarcinoma of the Middle Third of the Esophagus Arising from Ectopic Gastric Mucosa. J. Thor. Surg. 37:398-403, 1959.
2. Carrie, A. Adenocarcinoma of the Upper End of the Oesophagus Arising from Ectopic Gastric Epithelium. Brit. J. Surg. 37:474, 1950.
3. McCorkle, R. C. and Blades, B. Adenocarcinoma of the Esophagus Arising in Aberrant Gastric Mucosa. Amer. Surg. 21:781-785, 1955.
4. Mingh, S. C. and Bullough, M. B. Coexisting Adenocarcinomas of the Esophagus and of the Esophagogastric Junction. Report of a case. Amer. J. Dig. Dis. 8:439-443, 1963.
5. Dodge, O. G. Gastro-eosophageal carcinoma of mixed histological type. J. Path. & Bact. 81:459-471, 1961.
6. Block, G. E. and Lancaster, J. R. Adenocarcinoma of the cardio-esophageal junction. Arch. of Surg. 88:852-859, 1964.
7. Robbins, S. L. Textbook of Pathology with Clinical Application. 2nd Ed. Philadelphia: W. B. Saunders Company, p. 651, 1962.
8. Stout, A. P. and Lattes, R. Tumors of the Esophagus. Armed Forces Institute of Pathology. Washington, p. 72, 1957.
9. Rector, L. E. and Connerley, M. L. Aberrant Mucosa in Esophagus in Infants and in Children. Arch. Path. 31:285-294, 1941.
10. Willis, R. A. The Borderland of Embryology and Pathology. London: Butterworths, p. 315, 1958.
11. Barrett, H. R. The lower esophagus lined by columnar epithelium. Surg. 41:881-894, 1957.
12. Azzopardi, J. G. and Menzies, T. Primary Oesophageal Adenocarcinoma; Confirmation of its Existence by the Finding of Mucous Gland Tumors. Brit. J. Surg. 49:497-506, 1962.
13. McPeak, E. and Warren, S. Histologic features of carcinoma of cardio-esophageal junction and cardia. Am. J. Path. 24:971-991, 1948.
14. Raphael, H. A., Ellis, F. H. Jr. and Dockerty, M. B. Primary Adenocarcinoma of the Esophagus: 18-Year Review and Review of Literature. An. of Surg. 164:785-796, 1965.
15. Smithers, D. W. Adenocarcinoma of the Esophagus. Thorax, 11:257-267, 1956.
16. Groves, L. K. and Effler, D. B. Cancer of the Gastric Cardia associated with Esophageal Hiatus Hernia. Surg. Gyn. Obst. 116:463-468, 1963.
17. Smithers, D. W. The Association of Cancer of the Stomach and Oesophagus with Herniation at the Oesophageal Hiatus of the Diaphragm. Brit. J. Radiol. 28:554-564, 1955.

There is one thing more exasperating than a wife who can cook and won't, and that's the wife who can't cook and will.—Robert Frost



THE DOCTOR'S LIBRARY

Atlas of Urological Surgery. By Philip R. Roen, M.D., F.A.C.S., Appleton-Century-Crofts, Division of Meredith Publishing Company, New York, 1968.

It is 17 years since the first edition of Roen's Atlas of Genito-Urinary Surgery appeared.

The present volume is more extensive and shows considerable improvement over the original one. The old line drawings have been replaced by superb wash drawings of almost photographic quality by the same illustrator. The text has also been expanded.

Although this book is pleasant and easy to read it seems, to this reviewer, that it presents some deficiencies which cannot be overlooked. The author is careless in his use of anatomic terms. Thus the transversus musle, for example, is called the transversalis muscle and the ilio-hypogastric nerve the hypogastric nerve.

Standard operative procedures such as the Boari flap and the Cooney Horton operation for post-operative incontinence in the male are presented without mentioning the names of the originators.

In places the text and the illustrations do not coincide exactly and the description and the illustration of the operative procedure are not presented in step by step fashion so as to serve as an exact guide to the future performance of the operation. The author takes the reader's knowledge too much for granted and often omits essential steps in the procedure. He fails to present accurately, for example, the exact placement of the sutures. The Cordonnier technique for uretero-sigmoid anastomosis shows only one layer of sutures instead of two and then this layer is not described adequately.

The short section on adrenal surgery is so sketchy as to be useless. Standard and well proved procedures are sometimes not even mentioned.

It seems that the section on transurethral surgery is wholly inadequate and would better have been omitted from a volume such as this.

In spite of these deficiencies, the book does serve as pleasant reading and should be of interest to the resident in training. It is not sufficiently detailed to be of value to the experienced Urologist.

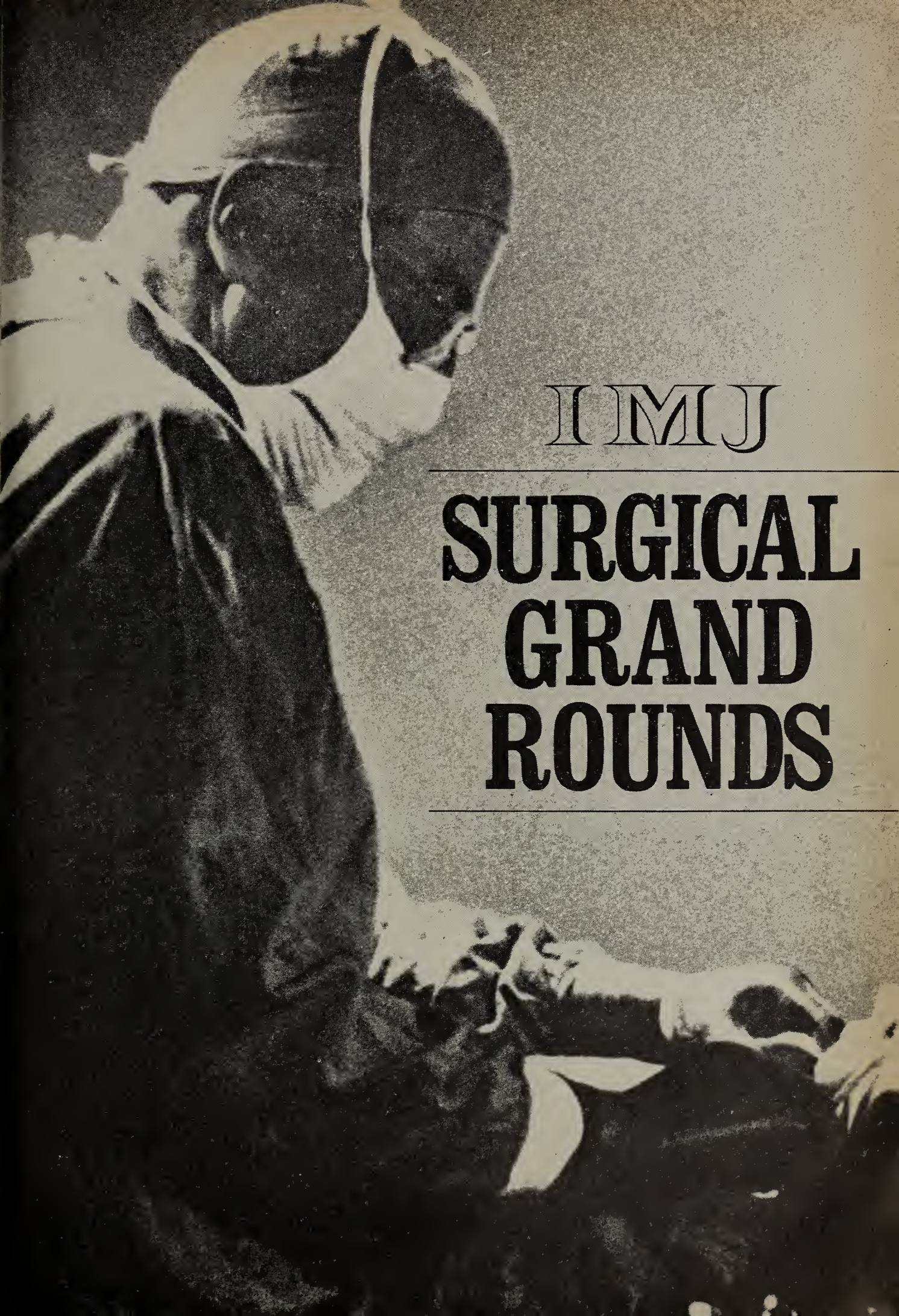
Frederick A. Lloyd, M.D.

Virological Procedures. J. Mitchell Hoskins, M.A., Ph.D. Appleton-Century-Crofts, New York, 1967. 358 pages, $13.75.

Microbiologists and others particularly interested in the strategy employed in diagnostic virology will find *Virological Procedures* valuable reading. This book begins with a brief description of facilities, equipment and biological supplies required for operation of a virology laboratory and an explanation of how these can be combined to isolate and identify viruses from clinical materials. It continues with a discussion of information needed to complete confirmation of virus infection and consideration of the applicability of these procedures to particular groups of viruses.

Dr. Hoskins has limited the procedures included in this book to those he personally favors, but has not written a cookbook. He has emphasized methods dependent on tissue culture techniques and has assigned a complementary role to those that use embryonated eggs and experimental animals. The result has been a book which seems more suited for use in planning than for use at the bench in the daily conduct of experiments.

Byron S. Berlin, M.D.



IMJ

SURGICAL GRAND ROUNDS

Pulmonary Embolism and Renal Failure

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on March 30, 1968.

Case Presentation:

Dr. David Winchester: The patient is a 62 year old white male, who was admitted to Chicago Wesley Memorial Hospital through the Emergency Room on Feb. 16. The day of admission he was walking down the street when he experienced an episode of dyspnea. He walked a few more steps, then collapsed and fainted. In doing so he struck his head. He was brought to the Emergency Room where he was conscious when examined. He had felt perfectly well the day of admission until this episode. He had a long history of epilepsy, which had been controlled with medication. In Dec., 1967, he fell down some stairs and injured his back. He continued to have discomfort for several days so that he sought medical attention. X-rays were taken and showed "pneumonia." According to the patient, the "pneumonia" was thought to be related to his injury. In addition, a history of mild, recently diagnosed gout was given. The patient also had been subjected to transurethral resection for benign prostatic hypertrophy twice in the past. History of cardiovascular and pulmonary disease was absent. When admitted to the Emergency Room the patient was in shock. His initial blood pressure was 60 systolic, pulse 120, respirations were 28 and labored, and temperature was 100.8°. He appeared cyanotic. The chest examination was essentially negative, and the abdominal examination was likewise unremarkable. The abdomen was soft and non-tender, and nomal bowel sounds were present. There were minor facial contusions. Peripheral pulses were intact. Hematocrit was 45 per cent, white count 16,000, and the urinalysis was negative. A central venous pressure catheter was inserted and the initial CVP was five. He responded promptly to plas-

ma infusion and his blood pressure rose to a normal level. An electrocardiogram revealed a right bundle branch block. His family physician stated that this finding had not been present. A nasogastric tube yielded approximately 50 cc. of Hematest-positive material. Thirty cc. of urine were obtained by catheter, but during the next few hours there was very little urinary output. Twelve and one-half grams of Mannitol were given in the Emergency Room and 120 cc. of urine was excreted in the next three hours. X-rays were taken in the Emergency Room of the chest and abdomen.

Dr. Abram Cannon: The chest film at the time of admission was not diagnostic. There was engorgement of the vessels on the right side. We have films of the abdomen which were made a little later. The abdominal film made in the Emergency Room demonstrated scattered gas in the abdomen without specific findings. Oblique and lateral films were obtained to see if the aorta might be the site of a possible aneurysm. There was a little calcium in the aorta, but we couldn't really come up with anything that was very helpful on this man. There was an old compression in the body of L-3.

Dr. Winchester: At this point diagnosis was unknown, but the possibility of a pulmonary embolus was considered. The patient was admitted, and during the course of the afternoon he experienced some shaking chills. His fever rose to 102°. Later on in the evening his blood pressure dropped to 60 systolic, and Aramine was necessary for maintenance of his blood pressure. His respirations increased gradually to 36 per minute. During the course of the afternoon he had complained of back pain, but not of abdominal pain. A lung scan was performed. The left lung failed to visualize on the anterior view, and only a small portion was seen on the posterior scan (Fig. 1). The right lung was reported to be normal in this perfusion scan. Heparin was started and the patient was digitalized. Because he developed another episode of hypotension during the evening with increasing difficulty in breathing, a pulmonary arteriogram was done in the evening about eleven o'clock. The left main pulmonary

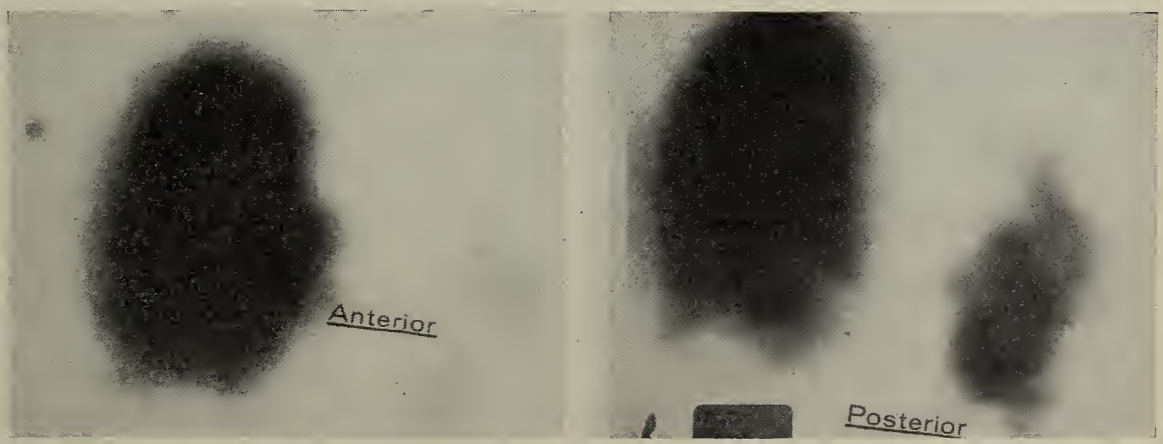


Fig. 1. **Lung scan using Indium ferric hydroxide demonstrates little uptake in the left lung, seen only on the posterior view. This is compatible with pulmonary embolism.**

artery did not fill. The patient tolerated this procedure very well. He was taken to the operating room and median sternotomy was performed. Cardiopulmonary by-pass was employed. The pulmonary artery was opened, and 12 to 14 clots were removed from both pulmonary arteries and branches. There were three or four clots that were three or four inches in length, and these were milked out by opening both pleural cavities and squeezing the lungs.

Prior to institution of cardiopulmonary by-pass his systolic blood pressure was 90. A perfusion pressure of 60 to 65 was maintained during the procedure. After the pump was stopped his pressure ranged from 80 to 120 systolic. Because he had continued to embolize on Heparin, a right transverse abdominal incision was made to ligate the inferior cava. It was soon apparent that there was a large amount of dark fluid in the peritoneal cavity which looked like blood. The peritoneal cavity was opened and was found to contain a large amount of blood. The incision was extended to the left side of the abdomen and a ruptured spleen was found and removed. The inferior vena cava was ligated. He was stable postoperatively, and his urinary output varied from 30 to 50 cc. per hour. On the second day his BUN was noted to be 54 mgm.%. The next day he became oliguric, and this progressed almost to complete anuria. His BUN and serum creatinine showed a gradual elevation and he became uremic. A renogram seven days after the onset of oliguria did not show obstruction. He was managed with hemodialysis. Nine hemodialyses were required during the next thirty days as he continued to put out no urine. Thirty-five days later he began to put out urine, and his BUN had begun to decrease although he still was azotemic.

Patient enters:

Dr. Arthur DeBoer: Do you remember very much of the surgery at all?

Patient: No, I didn't even know I had had an operation.

Patient leaves:

Dr. John Beal: Dr. DeBoer, I wonder if you would tell us what led to your suspicion that he had a pulmonary embolus. There are a number of unusual features here; the initial low central venous pressure, for example.

Dr. DeBoer: He was admitted from the Emergency Room to the medical service and we were called about eleven o'clock that night. I think it brings out a couple of things. One is the fact that this man who arrived in shock with a very suspicious clinical picture of a pulmonary embolus because of his severe tachypnea and cyanosis, but after a couple of units of plasma his blood pressure promptly rose from 60 to 100 and his central venous pressure remained low. Then with a negative x-ray of his chest suggesting no intra-pulmonary pathology the tachypnea and cyanosis must be considered strongly as caused by a pulmonary embolus. With a negative x-ray of his chest and a positive pulmonary scan, I think this is fairly convincing evidence of a pulmonary embolus. He was treated then as having a pulmonary embolus, in spite of the fact that on two occasions he responded to the administration of plasma and I.V. fluids by an increase in blood pressure and urinary output. With a history of epilepsy, a bruise on his face from falling, and the persistence of back pain of which he complained, one becomes exceedingly uncomfortable with the diagnosis of pulmonary embolus. I considered the possibility that perhaps the pulmonary scan abnormality was a residuum of the pneumonitis he had a couple of months ago. With all these complex variables the diagnosis of pulmonary embolus had to be proven before an operation could be considered. Did this man have a myocardial infarct evidenced by changes in the EKG? Did he have a ruptured peptic ulcer with blood in the stomach thereby giving him pain and chills and fever of 102° that afternoon? Or did he really have a pulmonary embolus? These were the considerations we entertained. A pulmonary angiogram was done immediately before taking him to the operating room. The angiogram was done in the heart station adjacent to the operating room while we were setting up the operating room and the pump. Pulmonary embolectomy, of course, is not a new operation. The old Trendelenburg procedure was done in the 1900's without cardiopulmonary by-pass. Following that, I believe, the first successful pulmonary embolectomy in the United States was done in 1958. Then in 1961 Sharp did the first successful pulmonary embolectomy with cardiopul-

monary by-pass. I think today there is very little justification for the old Trendelenburg procedure; that is removing the clot from only one pulmonary artery. It would be kind of enticing to open up just the left pulmonary artery in this case. But almost invariably if a pulmonary embolus is massive enough to cause hypotension more than just one lung is occluded. One can almost always find clots in the other side. Therefore, it is said that more people have died from the Trendelenburg procedure, that is unilateral pulmonary embolectomy, than have been benefited. I think this is also true today. The preferred method of pulmonary embolectomy is with cardiopulmonary by-pass to remove the clots from both lungs. If one looks carefully on the angiogram you can see the clot defect floating in the right pulmonary artery as well. The second part of the operation is, of course, to ligate the vena cava providing the patient is in satisfactory condition. We have had a couple of patients who had low blood pressure after the pulmonary embolectomy and with questionable central nervous system efficiency because of prolonged hypotension preoperatively and I elected not to do a vena cava ligation. With this man I felt we should do a vena cava ligation, and this decision became the life saving feature of the operation, because when we did the retroperitoneal dissection I saw evidence of blood in the peritoneal cavity.

I previously had another case with a ruptured spleen associated with a massive pulmonary embolus and failed to recognize the torn spleen. However, when we saw blood in the peritoneal cavity as the vena cava was being exposed for ligation, the spleen was exposed and a two inch laceration of the spleen was found. The cause of the ruptured spleen could be due to the initial fall, or possibly from sudden elevation of the venous pressure due to obstruction of the pulmonary arteries. It seems reasonable if the central venous pressure is low and a massive pulmonary embolus has been demonstrated that the possibility of an injured spleen must be considered.

Another interesting factor in this case is that this patient developed a high output renal failure postoperatively. I am sure this is not uncommon. Usually, if there is good urinary output, we don't worry too much about kidney failure. This man had an hourly urinary output of about 40 cc. but was obviously in renal failure as evidenced by a rising BUN and creatinine. I presume it was caused by repeated episodes of low blood pressure prior to the time we saw him. He came into the Emergency Room at 11:00 a.m. and we saw him about 11:00 p.m. after two periods of hypotension and very little urinary output. It was because of his lethargy and his slurring speech that we were alerted. I assumed that his BUN was rising because of blood hemolysis, but his creatinine was also elevated and this was the clue that there was some renal failure. I think this is an unusual picture for tubular necrosis. After dialysis he never did develop diuresis, he just gradually started putting out urine. However, I have had very little experience with successful dialysis. In fact, I have repeated several times, this is the first man I have seen survive following dialysis. But the patients I refer for dialysis are following ruptured aortic aneurysms, and these are all in the older 60 to 70 year age group. This man is alive today because of the persistence of the dialysis team.

Dr. Beal: Do you think the Aramine might have contributed to the renal failure?

Dr. DeBoer: Aramine is a bad drug for the treatment of hypovolemia. If one uses central venous pressure as a guide in the treatment of hypotension I am sure vasopressor agents such as Aramine would seldom be used in the presence of hypovolemia. It is safe to give parenteral fluids in an unlimited quantity if the central venous pressure does not rise.

Dr. John Grayhack: This is a peculiar type of postoperative high output failure. I have seen it before and it is difficult to understand. The patient has a high output for about 24 hours and suddenly becomes oliguric as this patient did. In the usual high output failure the patient maintains a high urinary output (1,000+cc. per day). His azotemin is discovered belatedly when his deteriorating clinical condition necessitates a search for a cause. The type of oliguric failure seen in this patient has followed multiple transfusions in my limited experience with it. The mechanism is unknown. Dialysis is as important an aid in management of these patients as it was in this instance.

THE VIEW BOX

By Leon Love, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School

The patient was a 63 year old diabetic female with a history of dysuria and frequency. Physical examination was unremarkable. The urine revealed 3+ mucose, 15-20 WBC, and 8-10 RBC.
What's your diagnosis?



Fig. 1

(Answer on page 821)

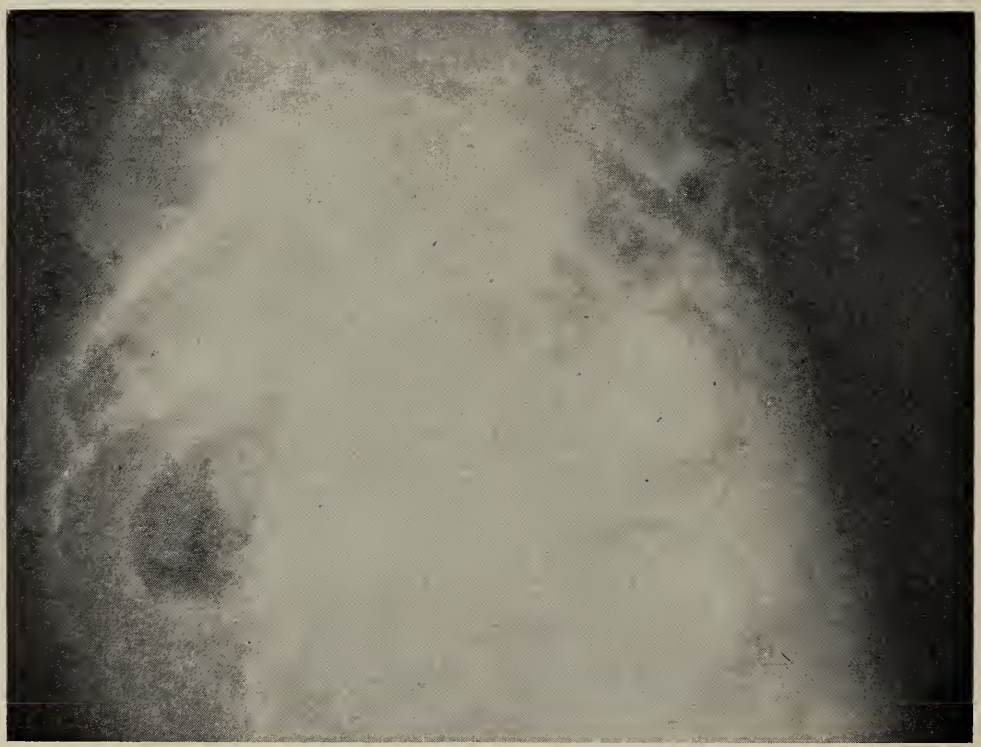


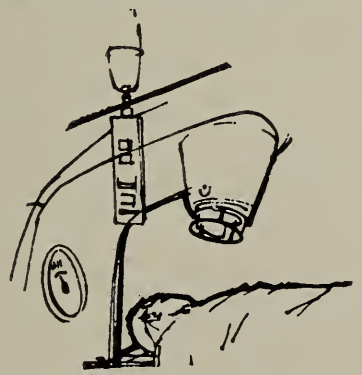
Fig. 2

Medical Progress in ARTIFICIAL INSEMINATION

By Charles T. Gerber, M.D./Chicago

From the throes of the sexual revolution is emerging a new idea of the family unit. The use of oral contraception is allowing the family to contain itself, arithmetically, within those bounds most feasible for its prosperous existence. Artificial insemination, on the other hand, has allowed expansion of the family unit to achieve its full potential in some cases in which it had become obscured in the disappointment of childlessness. As with any new concept, artificial insemination will require a great deal of refinement, but through its judicious use it may rid itself of shackles similar to those which impeded the progress of so many other fields of medicine upon their inception. This presentation attempts to place it in an appropriate perspective in the area of infertility investigation and treatment.

Medical Progress



Harvey Kravitz, M.D.
Medical Progress Editor

Dr. Gerber is Chief Resident, Department of Obstetrics and Gynecology, Michael Reese Hospital, Chicago.

Modern society is undergoing a curious metamorphosis in the field of general medical awareness. Diagnostic advances have transformed microscopic cellular change into the headline CANCER emblazoned in the cerebral cortex of the American public. One of the latest medical advances, "the pill," has entered the mind if not the body of nearly every married, marrying and marriable woman in this country. It has altered the social and moral habits of the country, is causing the revision of theological doctrine, and may eventually be known as the cause of the sexual revolution.

There is another aspect of the sexual revolution which is seldom publicized and instead is shrouded in mystery and misgiving. Little is known about artificial insemination mainly because silence is one of its prerequisites; but silence perpetuates ignorance; ignorance propagates fear, and fear intolerance. And so it is that this aspect of medical progress has not come to share in the limelight of sexual modernity.

Some form of contraception is said to be practiced by between 55% and 75% of married couples in this country. This figure would be increased still further if it could be broadened to include the 10-15% of all marriages which are childless. The popular belief that childlessness is the fault of a "barren" female is quite passé and the finding that 35-40% of childless marriages are due to the male partner is a new burden which must be borne by the male ego. As a result of this male factor

there are some one million potentially fertile women in this country who are married, but who cannot conceive. In a study of 300 infertile couples by Varangot *et al.* the responsibility for the infertility was placed on the husband in 30.5%, the wife 25.5% and jointly by both partners in 44% of the cases.[1]

Fundamentals of Reproduction

In order to better understand the etiology of infertility it is necessary first to review certain fundamentals of the reproductive process. Through the diligent efforts of many workers certain standard values have been established in an attempt to define the boundaries of fertility. To achieve fertilization the average semen specimen, for example, should be 2-4 cc. per ejaculate; there must be 40-100 million spermatozoa of which at least 80% must be of normal morphology and 70% must be actively motile.[1] Using these as our criteria we are able to gain insight into the abnormal semen specimen which is not capable of achieving conception. A list of these semen abnormalities is given in Table I.

Table I.

SEMEN ABNORMALITIES

A-spermia—absence of ejaculate
Azo-spermia—absence of sperm in ejaculate
Necro-spermia—absence of living sperm in ejaculate

Hyper-spermia—ejaculate greater than 6 ml.
Hypo-spermia—ejaculate less than 1 ml.
Oligo-spermia—less than 60 million sperm per ml. of ejaculate

In an evaluation of the semen of 1000 fertile men, MacLeod and Gold were able to demonstrate the direct relationship between the number of sperm and the fertility of the subject.[2] (Table II.)

There are many diverse factors which may account for the male role in infertility. Some of these (hot baths, tropical climates) may be easily reversed by proper management and hygiene. Other factors such as infection, tumors, hormonal therapy or congenital anomalies are based upon the inability of the husband in the mechanical act of insemination. These may be of an anatomic (hypospadius), physiologic (hostile cervical mucus) or psychologic (premature ejaculation) nature.[1]

Table II.

RELATIONSHIP BETWEEN SPERM COUNT AND FERTILITY*

Spermatozoa (Million/ml)	Fertility (%)
<1	0.1
<10	2.0
<40	16.0
<60	29.0
>60	47.0

*Series of 1000 fertile men (MacLeod and Gold)[2]

Basic Process Described

The term "insemination" refers to the deposition of seminal fluid within the vagina. To simplify this still further let us draw an analogy with the depositing of money within a bank. In order for this to occur there must be 3 factors: a depositor, a bank, and of course, money. Were any of these factors to be absent this transaction could not occur. The object of the transaction is that money be placed in a bank; who deposits the money or by what means he reaches the bank matters little so long as the objective is accomplished. If the objective of the childless couple is to have children, then 3 factors must be present: first, there must be sperm and semen (according to the criteria of fertility I have described); second, there must be the "fertile female" (with all of the ramifications that the term implies); and third, there must be a method of achieving deposition of the seminal fluid into the vagina of such a fertile female.

If the husband were able to produce seminal fluid and achieve insemination through coitus with his fertile wife, then the couple's childless state would be short-lived. If the husband produced "good" sperm but was not able to achieve insemination due to some anatomic, physiologic or psychologic factor the couple's fertility would go unrewarded. The collection of a semen specimen from such a husband by a physician and the deposition of this specimen into the vagina of the man's wife might very well achieve conception and subsequently the birth of the couple's child. The child is theirs. It is the product of union of the germ cells of husband and wife; it bears their genes; it is living and real. The child is hardly "artificial" as the term "artificial insemination" implies. This term "artificial insemination" or "AI" has been one of the major drawbacks to the general public acceptance of this proce-

Table III.

MILEPOSTS IN HISTORY OF ARTIFICIAL INSEMINATION[1,5]

220 A.D. Talmud
Questions paternity of child born of a woman accidently fertilized in bath water
1200's Rabbi
Questions fertilization of a woman sleeping on a linen contaminated by male ejaculate
1300's Arab Shiek
Inseminated a pure strain of his enemy's fine mares with semen from sick inferior stallions
Varasotto
Artificial insemination in sheep
1400's Don Ponchom
Artificial insemination in fish
1550 Bartholomeus Eustachius
Advised digital guidance of semen toward the cervical os following coitus
1677 Louis Van Hamman
Discovery of spermatozoa
1775 Spallanzani
Artificial insemination in reptiles and dogs
1790 Dr. John Hunter
Achieved the first recorded pregnancy and delivery of a child conceived through AI
1838 Girault
Blew sperm into vagina through hollow tube
1866 J. Marion Sims
First successful AI in the United States
1870 Courty
Coitus condomatosus
1876 de Lajatre
88% successful treatment of 567 women
1884 Pancoast
First artificial insemination donor

dure. Popular terms arose, such as "test tube babies" and "instrumental pregnancy,"[3] which added to the sense of artificiality and unacceptance. And yet the child is real, not artificial. He was conceived in the womb of his mother and nursed at her breast. He is not born from a test tube heated over a bunsen burner. The fallacy of the belief that pregnancies conceived by "artificial" insemination (and I use that term only because it avoids adding another term to the morass of nomenclature that is medicine) is different from those conceived by coitus is borne out by the facts that (1) there is an equal incidence of abortions or stillbirths (although only 2% abortion occur in some series), (2) there is no difference in the ease of prenatal course and confinement, and (3) the incidence of fetal anomalies is not increased[1]. Artificial insemination has, however, been shown to (1) result in fewer multiple births, and (2) have a higher male:female sex ratio (160:100) than pregnancies resulting from coitus (105:100)[4].

The history of AI is certainly interesting as it parallels the development and sophistication of medicine in general. As history depends on accuracy for its validity, the history of AI is incomplete because of hesitancy of its pioneers to publish their results and to encourage its use. Table III presents some of the highlights in the development of artificial insemination[1,5].

In considering the technical factors involved in artificial insemination we must first review the methods of semen collection. Table IV presents a list of some of the methods[1]. These methods are, for the most part, self explanatory. It is of historical interest that the founder of coitus condomatosus was Antonius Liberatis who, in 150 AD describes the use of an artificial membrane prepared from a goat's bladder to prevent the fertilization of the wife of King Minos of Crete.*[,1] Coitus condomatosis is no longer used for AI for several reasons:

1. insufficiently aseptic;
2. inability to maintain required temperature;
3. partial loss of volume on removal;
4. adverse effect of incorporated chemicals (rubber, powder are sperimicidal);
5. reduction in duration of motility.

As regards sperm motility, Bilding has shown that sperm from masturbated specimens retain motility for 105 hours under optimal conditions, while sperm from coitus condomatosus placed under similar conditions have adequate motility for only 35 hours.[1]

Semen Collection

The manner of collection of the semen specimen may greatly enhance the suitability of a given specimen for use in achieving conception. The first third of the ejaculate has been found to contain up to 75% of the spermatozoa; hence by division of the ejaculate at the time of collection a more concentrated specimen may be obtained. The centrifugation of a semen specimen has also been used and has shown that the number of active sperm is increased to 89%.[1]

Once the specimen has been obtained it

* The term "condom" has a diverse origin, including the following possibilities:[1]
1. Conton—the French physician who is said to have invented it;
2. Condom—a French town;
3. "condus" (L)—someone who guards or preserves something;
4. "kondu" (Persian)—a vessel in which something is stored.

may be treated in such a manner as to enhance its fertilizing capability. Freezing of the semen specimen with the addition of glycerol, isopentane, liquid nitrogen or dry ice has enabled up to a 67% three-month survival rate.[1] The use of such methods has led to the establishment of semen banks which aid in building large supplies of sperm from which samples may be drawn when needed. Such a semen bank calls upon the physician to sacrifice anonymity of the procedure by the employment of such staff as is necessary for the proper organization. If, on the other hand, such anonymity is maintained he risks the problem of mistaken identification of semen.

The addition of certain factors to the semen has been shown to increase its conceptual capabilities. Hyaluronidase facilitates sperm penetration of the oocyte by causing disruption of the corona radiata. The addition of a testicular enzyme has been shown to dissolve cervical mucus thus facilitating sperm transport. Alpha-amylase prolongs sperm motility by maintaining liquefaction of the semen. Penicillin destroys harmful bacteria. Certain diluents enhance sperm motility, including Ringer-Locke and physiological salt solution.[1]

Table IV.

METHODS OF SEMEN COLLECTION

A. Post Coital
   1. Vagina
   2. Bladder
   3. Urethra
B. Intracoital
   1. Coitus interruptus
   2. Coitus condomatosus
C. Extra Coital
   1. Masturbation
   2. Massage of seminal vesicles
   3. Electrically induced ejaculation
   4. Nocturnal emission
D. Other
   1. Testicular or epididymal punctate
   2. Semen from a corpse

The time of insemination of a collected semen specimen must be chosen in accordance with the time of ovulation. Such methods as basal body temperature, cervical mucus (Spinnbarkeit), vaginal smear, endometrial biopsy, rat ovary hyperemia test as well as clinical symptoms have been useful in attempting to detect the time of ovulation. The longer term of viability for spermatozoa (24-72 hours) than the ovum (12 hours) suggests that insemination should be performed shortly before ovulation rather than after it.[1]

Locale

The site of insemination may be one of many. The semen may be placed in the posterior fornix of the vagina (intravaginal), in the vicinity of the external cervical os (paracervical) or to a depth of a few millimeters beyond the external os (intracervical). These are the most commonly used sites in AI. It may also be placed beyond the internal os (intrauterine) or near the ostia of the fallopian tubes with pressure exerted to enable entrance into the tubes (intra-tubal). Intraperitoneal methods such as paraovarian deposition or injection into the pouch of Douglas are seldom used. The intrauterine technique has been found to cause both severe colic-type pain and an increased incidence of infection.[1,6]

Several methods have been used in an attempt to prolong the contact of semen with the external cervical os. The semen might thus be protected from vaginal acidity and the determination of exact time of ovulation would no longer be as critical a factor in achieving conception. The cervical cup, spoon, sperm chamber, and vaginal diaphragm are but a few of these methods.[1,6]

In our discussion heretofore, we have considered the husband as the source of semen for artificial insemination. Of primary importance in the evaluation of a woman for the problem of infertility is a careful evaluation of the husband's semen and sperm. As has been inferred, should the couple's infertility be based on a deficiency in the husband's semen (or sperm) another source must be found. This is another phase of AI termed, appropriately, Artificial Insemination Donor or AID.

Donor Selection

The selection of a donor is critical.[1,7] This selection may be made by the couple; he may be a member of the husband's family. On the other hand, the selection may be made by the physician, in which case the donor may remain unknown to the couple. In some instances committees have been created for the selection of donors. Such a committee may include a gynecologist, urologist, psychiatrist, geneticist and biologist.

The qualifications of a prospective donor are numerous. The precision with which the donor is selected will determine the

measure of success in this procedure. He should be of proven fertility: some physicians require that he be the father of at least two healthy children. He must be free of any illness which may be transmitted to the fetus (or to its mother). He should be matched phenotypically with the husband as closely as possible, that is he should physically resemble the husband in body build as well as hair and eye color. Racial differences must be carefully avoided. Blood groupings are essential in that the Rh of the donor must be similar to that of the prospective recipient. Similarities in religion have the advantage of avoiding any psychological problem on the part of the parents. Some physicians prefer donors over 30 years of age to avoid such diseases as schizophrenia which are likely to have become apparent by this age.[1,7]

Such features as character, temperament, cooperative spirit, education and the like, although seemingly general in overall scope, certainly add to the precision of selection when applied to donor-husband matching.[1]

As a group, medical personnel (residents, interns and medical students) are most readily available to serve as donors. It is also felt that such a person, if afflicted with a transmittable disease, would be more likely to recognize the presence of such an illness and seek treatment for it. Financial remuneration for donors has become established, the sum varying from $5 to $50 and averaging $15 to $25 per ejaculate. As can be imagined, there are some "professional" semen donors. The use of pooled semen specimen from several donors may add to the anonymity of the specific donor but certainly serves to lessen the similarity between donor and husband.[1]

Problems

As might be expected, there are many problems involved in the field of artificial insemination. Difficulties in infertility evaluation, technical problems in collection and instillation of semen specimen, and problems in selection of a donor have already been discussed.

There are other problems confronting artificial insemination, such as problems in the fields of psychiatry, law and religion which may not be overcome for many years and even then will require some great social change.

Consider first the husband who is made aware of his critical role in his wife's inability to conceive. He may adopt feelings of inferiority and a lack of manliness. He is to "blame" for his wife's frustrations and longings. His instinct for survival and drive toward fatherliness (as a form of self-perpetuation) are abruptly halted. He assumes the sense of personal degradation and may be consumed by the fear that his inadequacies may be discovered by others. A child begot by donor insemination is a constant reminder of his failure. He may develop a pathologic jealousy for his wife whose conceptual ability has become evident, and toward the donor who has fathered a child who should be his own child. He develops a hatred and aversion for this "alien" child who has succeeded in stripping him naked in front of the world, if only in his own mind.[1,8,9,10]

The wife is relieved to learn of her husband's causative role in the couple's infertility. She has been "cheated" by her husband's deficiency. Her hostility may seek revenge through AID and her overindulgence of her baby serves to exclude her husband. She may come to challenge her husband's masculine role on material matters, in his occupation and the like. She may develop a yearning to know the identity of the donor; this yearning may become an obsession. The donor likewise may yearn to know of the recipient's identity; the fathering of unknown children may weigh heavily on his psyche. The donor's secrecy from his own wife may lead to distrust. Flattery of his male ego may grow into feelings of a superman. Financial greed may supercede feelings of compassion and idealism.[1,8-10] According to Gerstel the participation in AI indicates an emotional disturbance.[8] It is not difficult to understand from the preceding that AI certainly exposes its participants to a multiplicity of psychological factors.

Legality

The legality of AI is unsettled.[1,5,10] The involvement of the participants of AID in adultery, as well as the status of the child are questions which have received divergent rulings in different courts. The wife's denial that she gave her consent for the insemination may indeed constitute rape by her physician as well as by an unknown donor. A birth certificate must bear the

donor's name as father or the physician is guilty of fraud. The donor's wife may seek a divorce because of her husband's extramarital sexual affairs. Were donor's anonymity not to exist a donor's child could demand support and inheritance right from the donor; and, on the other hand, a donor might demand support from a wealthy AID child.

Many attempts have been made to contain AI within the legal framework of our society. The mixing of husband and donor semen, as described previously, retains legitimacy of the child; the more the semen specimen is diluted with ineffectual husband's semen the less the chance of conception. The signing of consent forms and the keeping of records, so as to protect the physician, lessen the secrecy of AI and secrecy may be its keynote for success. The adoption of a child conceived through AI appears the most certain method of assuring its legitimacy. The Bureau of Legal Medicine of the AMA summarized the problem of legality of artificial insemination thusly:

> *No act is illegal unless prohibited by some law, either written or unwritten, and society has formed no opinion and enacted no law regarding artificial donor insemination.*

The overlapping influences of church and state have served to mold our present society. It is thus understandable that AI with all of its complex social and legal ramifications will also be influenced by religion. The implication of adultery and illegitimacy is of religious as well as legal import. The Roman Catholic Church denounced AI in 1877 and Pope Pius XII rejected it absolutely in 1949. The committee of the Archbishop of Canterbury in 1948 had stated that AI was "contrary to Christian principles and morals and worthy to be considered a criminal offense."[5]

In addition to adultery and illegitimacy the problem of incest plays a dominant role in religious condemnation. With the anonymity of AID there exists the possibility that two children produced by AID might marry and their marriage would be that of a brother and sister. The possibility of such a marriage certainly exists but, according to Rubin,[10] "even if AID increased by twenty times in England there would be no more than the possibility of one consanguineous marriage every 50-100 years."

References

1. Schellen, A. M., Artificial Insemination in the Human. Amsterdam, Elsevier, 1957.
2. MacLoed, J. and Gold, R., "An Analysis of Human Male Fertility," *Int. J. Fert.* 3:382, 1958.
3. Finegold, W. J., Artificial Insemination, Springfield, Illinois, Charles C Thomas, 1964.
4. Seymour, F. I. and Koerner, A., "Artificial Insemination; present status of U.S. as shown by recent survey," *JAMA* 116:2747, June, 1941.
5. Watters, W. W. and Sousa-Poza, J., "Psychiatric Aspects of Artificial Insemination," *Canad. Med. Assoc. J.* 95:106, July, 1966.
6. Guttmacher, A. F., "Artificial Insemination," *Ann. N.Y. Acad. Sci.* 97:623, Sept., 1962.
7. Weisman, A. I., "Symposium on Sterility and Fertility," *West. J. Surg.* 50:142, 1942.
8. Gerstel, G., "A Psychoanalytic View of Artificial Donor Insemination," *Am. J. Psychother.* 17:64, Jan., 1963.
9. Deutsch, H., The Psychology of Women. New York, Grune and Stratton, 1954.
10. Rubin, B., "Psychological Aspects of Human Artificial Insemination," *Arch. Gen. Psych.* 13:121, Aug., 1965.
11. Medicolegal Aspects of Artificial Insemination: A Current Appraisal. *JAMA* 157:1638, April 30, 1955.

Coronary Artery Disease

The results of our study appear rather alarming; in our 100 patients with classic angina pectoris and angiographically proved coronary obstructive lesions, only 12 had lesions limited to a single coronary branch, and 17 to two vessels. In 71 cases, the three main arterial trunks, together with one or more secondary branches, were the seat of vascular lesions. In 58 of the 100 individuals it was possible to demonstrate complete occlusions in one or more segments, with a total of 68 occlusions. . . .

These data indicate once again that coronary artery disease, when capable of producing clinical symptomatology, has already acquired the stature of an extensively morbid process, with multiple areas of localization in the coronary tree. In about 70 percent of the cases, this involves the three main trunks and their secondary branches. (G. G. Gensini and C. Buonanno. Coronary Arteriography. Conclusion. Dis. of the Chest (Aug.) 1968; **54**:2; pgs. 91-99.)

Dr. Samuel Van Meter and the Illinois Medical Infirmary, 1857-1877



By Harold M. Cavins, Ed.D., and Harry Read/Charleston

Sam Van Meter at 15 was a tanner's apprentice. Dr. Samuel Van Meter at 44 had built a medical practice into an infirmary in Charleston that grossed $186,000 in one year (1868). In between he fought Indians and white renegades on a goldrush junket to California, and helped patch up the shooting victims of the Civil War-spawned Charleston Riot.

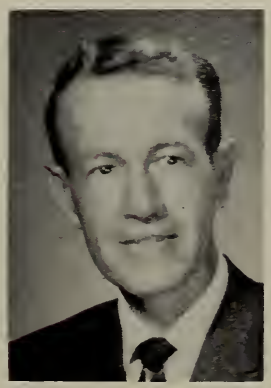
Van Meter occasionally mixed his medicine with morality—he once refused to treat a patient until the fellow agreed to forsake his saloon business[1]—and with tongue-in-cheek philosophy after an ill-advised excursion into the field of canine problems: after prescribing a remedy aimed at curing a dog of sucking eggs, he was told that the antidote had killed the dog. The doctor replied, "Well, he won't suck eggs anymore."[2]

The doctor also had the kind of incisive wit that night club comedians need to put down hecklers. On this occasion he was riding his horse down the street carrying a cabbage head he had received from a patient. A young man yelled, "There goes two cabbage heads on horseback." The doctor replied, "Young man, do you know the difference between this cabbage and you? It has had a sight more cultivation than you have had."[3]

Dr. Van Meter operated the Illinois Medical Infirmary in Charleston for 20 years. It closed its doors in about 1877 "when the doctor, worn out with his constant and arduous labors, retired from the active practice of his profession."[4]

The Infirmary opened in about 1857 and during its peak years published "The Nation's Journal of Health." An (undated) issue* of the publication ("Devoted to the Suffering Fathers and Sons, Wives, Mothers and Daughters of America") proclaims that "Health is the first want of the Individual, the Nation, and the Race," and it cautions its readers to "Care well for the Tabernacle of the Flesh, that Prosperity and ripe old age may be yours."





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*Undated, but marked No. 9, Vol. XXX; internal evidence indicated it appeared in about 1875.

The yellowing, brittle pages of the Journal bear mute evidence to the esteem in which former patients held Dr. Van Meter and his infirmary. It contains some 25 testimonial letters (or excerpts) plus the names of 265 references. Among this group are the names of 30 elders (apparently his prestige group), 17 reverends, seven doctors and approximately 215 patients. Readers were admonished to "Enclose a stamp and WRITE to some of the above references."

A breakdown of addresses shows persons given as references lived in Illinois, Missouri, Kentucky, Iowa, Indiana, Tennessee, Ohio, North Carolina, West Virginia, Nebraska, Alabama, Kansas, Texas, Georgia, California, Wisconsin, Michigan, Arkansas, Pennsylvania, Mississippi, Minnesota, Louisiana, and Canada.

One of the letters of testimony was signed by a County Court Judge from Missouri. It reads:

> "You may refer all doubters to me. Among a score of others benefitted by you in this community was a nephew of mine, who went to you when a mere skeleton, and his doctors and friends believed he could not live longer than one month. He is now well, and weighs more than he ever did before he was sick."
>
> "Tell them I know money is not your sole object. That once when I was at your Infirmary, you examined a man, and told him that no doctor on earth could benefit him, but to go home and save his money. The man told you he had come 600 miles, and if you could benefit him, money was no object. You told him to be wise, go home and straighten up his affairs, save his money for his children; that you could not cure him. . . ."

Dr. Van Meter told potential patients via the Journal that "the afflicted are invited to visit our Infirmary, and if they are not convinced that it is one of the best appointed institutions in the whole country, and do not believe that we understand the treatment of Chronic Diseases thoroughly, and have not the necessary means for their successful treatment, then we agree TO PAY YOUR HOTEL BILL WHILE HERE."

The Journal declared:

> "We treat all diseases of the Throat, Lung and Head, Consumption, Catarrh, Asthma, Bronchitis, Ulcerated Sore Throat, Affections of the Heart, Piles and Fistula, Diseases of the Liver, Dyspepsia, Rheumatism, Scrofula, Affections of the Eye, Deafness, Salt Rheum, Erysipelas and all Skin Diseases, Epilepsy, Diabetes, Diseases of Males and Females, Private Diseases, and Chronic Diseases of all other forms and types."

It was reported that patients came to the Infirmary "from the Pacific Coast, and from England, and other countries beyond the sea."[5]

A contemporary Charleston city directory placed the location of the Infirmary on the south side of the square, across the street from the courthouse. At about the time Dr. Van Meter retired from the operation of the Infirmary, Charleston, as a "health center," had a population of 3,136 (White males, 1,468; White females, 1,637; Colored males, 19; Colored females, 12).[6]

Samuel Van Meter was born in Grayson County, Ky., in 1824. His father was killed in a fall from a horse in 1827 and his mother, Catherine Keller Van Meter, brought the family of five children to Coles County. Young Sam had a common school education, and at 15 he was apprenticed to a tanner.[7]

Sam apparently decided that the life of a leather worker was not his calling and his mother purchased his time from the tanner. He then began to study with Dr. T. B. Trower, a native of Albermarle County, Va. Dr. Trower came from Kentucky to Shelbyville, practiced medicine there and was an officer in the Moultrie County bank. Dr. Trower studied medicine under Drs. Beamiss and Merryfield, of Bloomington, Ky.[8] He moved to Charleston in 1836, where he lived for 42 years, and at one time was a vice president of the Charleston First National Bank.

Under the precept system of the time, the student would make calls with the doctor. On the return trips by buggy, doctor and student would discuss the cases. First hand observation and discussions, plus dedicated work in Dr. Trower's medical library, added up to Van Meter's education in medicine.

There was nothing unusual about Dr. Van Meter's method of obtaining a medical education. The first doctor in Springfield was Gershom Jayne, who had no formal medical education, other than preceptor-

ship. He was a noted physician and a friend of Abraham Lincoln. His two sons were among the first native Illinoisians to attend formal medical schools. The majority of the early doctors served preceptorships before medical schools were organized in St. Louis and Chicago. Some of the earliest doctors who helped organize societies, including the Illinois State Medical Society, had no intramural formal medical education.

In 1850, when he was 26 years old, Dr. Van Meter was employed by five men from Chicago to accompany them to California as the party's doctor. He was paid $5,000 in gold before he left. The prudent physician left $4,000 at home with his wife, sewed $1,000 in his clothes, and headed west. The small party had a number of brushes with Indians and with white men seeking to steal horses.[9]

Dr. Van Meter remained in California for several months, but apparently found only a small amount of gold. His return trip was made in a sailing vessel to the Isthmus of Panama, a mule train trip across the isthmus, another ship to New Orleans, then home.

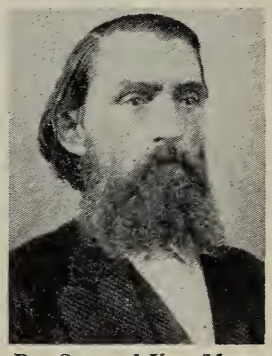
Van Meter practiced with Dr. Trower for three years after his return to Charleston, before launching his own practice about 1854. Dr. Van Meter then had a partner in the Infirmary for a number of years, Dr. H. R. Allen. Dr. Allen eventually left Charleston to become proprietor of the National Surgical Institute, Indianapolis, Ind.

In 1868, the year the Infirmary grossed $186,000, expenditures of $1,400 per month at the Charleston post office for postage were recorded.[10] The Journal describes the Infirmary "as the peer of any similar institution on the Western continent and a monument to the skill, energy and honorable calling for its founder. . . ."

Van Meter, via the Journal, declared that the success of the Infirmary was reached by "constant study, by persistent, untiring, unremitting labor. We have it on the best authority that the great part of what is generally termed genius is these things. The great pianist Rubenstein, when asked how it was that he attained such wonderful success in his art, replied, as if surprised by the question, 'It is only by Study.' " "Michael Angello [sic], when he was an old man said, 'I carry my satchel still,' thus indicating that his was a life of perpetual study and preparation."

Dr. Van Meter also emphasized that man must have a specialty ("Agassiz knew nothing of music" and "we do not take our watches to a blacksmith to have them repaired"). The doctor apparently referred to the general field of medicine as his specialty, without intending to single out a specialty within the field.

Although he doesn't use the word, Dr. Van Meter was an eclectic: "We do not ride a 'hobby' or run a theory. We take advantage of every remedy that is good . . ." And: "The Illinois Medical Infirmary stands upon its own footing, free from the influence of dogmas, untrammelled by creeds or schools. To cure our patients is our sole desire, and we care not whether the remedy was recommended by some high-toned professor or originated in the practical brain of our grandmother."



Dr. Samuel Van Meter

The doctor warned in the Journal that the Infirmary had no "agents" elsewhere in the country. He also tried to assist the ill and infirm in their pilgrimages to the Infirmary:

> "For the benefit of those living at a distance, and would like a reliable map to ascertain the best route to Charleston, we have just published at considerable cost a large and handsome chrome map of the United States, printed in four colors, and containing all the railroads in the country. This map is suitable for an office or a private dwelling. Every home should have a map on its walls. It is useful to both parents and children. The map will be sent to any address on receipt of six cents."

On March 28, 1863, the Charleston Riot made coast-to-coast headlines when, in a pitched battle on the courthouse lawn between anti-war Democrats and Union soldiers home on leave, nine men were killed and twelve were wounded.

When the shooting started, Dr. Van Meter took his six-year old son to the family residence, three blocks away, then

returned to attend to the bleeding victims of the riot throughout the remainder of the day and night. The day after the Riot Dr. Van Meter was walking down the street when a soldier, one member of a detail, pointed to him and called, "There goes a Copperhead! Shoot him!" However, the officer in charge of the detail knew the doctor well and no trouble developed. Probably because of his Kentucky background, the doctor was a Southern sympathizer (as were many people in Charleston), but did or said nothing disloyal to the Union.[11]

In contemporary accounts, Dr. Van Meter was described as a "remarkable personality." He was reported as having a "lithe, slender figure, straight, coal-black hair, black eyes and swarthy complexion. . . ."

"He was a man of boundless energy, and, as a boy, was the wonder of all his schoolmates by reason of his originality and daring. He was a natural mimic, brimming over with animal spirits and constantly surprising by his witty comments and retorts."

Records in the Coles County Courthouse indicate that Dr. Van Meter became an extensive property owner. He gave a son 1,000 acres of farm land and gave his two daughters large tracts of land in Douglas and Coles counties. One of the doctor's brothers, Keller Van Meter, was killed while serving with the Confederacy.

Dr. Van Meter died on September 18, 1902 at the age of 78. His wife, Frances, died on January 31, 1917, when she was 88. Dr. Trower died on April 15, 1878. All three were buried in Mound Cemetery, Charleston.

References

1. Editor, Southern Christian Weekly, Rev. L. W. Scott, quoted in Dr. Van Meter's "Journal of Health."
2. Correspondence with Mr. Craig Van Meter, Mattoon, Ill., grandson of Dr. Van Meter, hereafter cited as Craig Van Meter.
3. Craig Van Meter (grandson).
4. History of Coles County, Illinois, Wm. LeBaron, Jr. and Co., Chicago, 1879, p. 536.
5. Ibid. LeBaron, p. 536.
6. Chas. Emerson & Co., Mattoon and Charleston, Illinois, City Directories, 1878-1879.
7. Op cit. LeBaron, p. 536.
8. Op cit. LeBaron, p. 535.
9. Craig Van Meter (grandson).
10. Op cit. LeBaron, p. 536.
11. Craig Van Meter (grandson).
12. History of Coles County, Edited by Edward Wilson, Munsell Publishing Co., Chicago, 1906.

Activists

Perhaps the greatest disadvantage of SHO (Student Health Organizations) will redound to the very students who most wholeheartedly espouse its causes. In their idealism, they tend to become increasingly intolerant of those whom they will succeed. They condemn the intern who becomes "A sarcastic, cynical, loudmouth tyrant," and they speak with disdain of the practicing physician whom they see as treating his patients carelessly and callously. This attitude is an intensification of the disparagement traditionally implied by references to "the LMD." It is also an unfortunately restricted prospect of medical practice. The adherents of SHO are so concerned with the community, the recipient of health care, that they are blinded to the problems of the supplier. Yet the exercise of good medicine is unavoidably a two-way interaction, and students who do not appreciate the stultifying constraints of routine, the discouraging impact of a "difficult" patient, and the distracting pressures of a competitive society may find adjustment incalculably difficult when their role is suddenly that of the house officer or practitioner. (Activists in Medical School. **New England Jl. of Medicine** [July 11] 1968; 279:2; pgs. 101-102.)

Single Daily Dosage of Griseofulvin in Fungus Diseases

By Roland S. Medansky, M.D./Chicago

Many patients find the routine of drug dosage not only complicated, but inconvenient. Attempting to remember whether or not they missed taking their last dosage often proves upsetting. Single daily doses of any compound are, therefore, preferable to both patient and physician since it means avoidance of error and convenience of administration. However, effectiveness of a single daily dose is still another matter. The ideal preparation is one which combines effectiveness and a single daily dosage.

In fungous infections, topical agents require a repetitive routine of applications which, if forgotten or used in error, often result in incomplete therapy. Moreover, there are certain conditions where topical agents do not completely achieve the result the physician is seeking. An oral preparation which is systemically active against various fungi would, in most instances, be preferable in such situations.

Such an oral antifungal preparation is griseofulvin. Griseofulvin, as an orally administered fungistatic agent, has become the drug of choice in treating Trichophyton, Epidermophyton, and Microsporum infections of the hair, skin, and nails.

Recently, a micronizing principle was developed which apparently increases the area and absorbability of its particles. The micronized griseofulvin (C_{17}, H_{17}, 0_6, Cl) is an odorless, white, thermostable powder which is prepared by a special dry milling procedure. The preparation is known as Fulvicin-U/F, (R)* a 500 mg. tablet of ultra-finely divided material for improved absorption and higher blood levels.

Kraml and his associates[1,2] found that serum concentrations of ultra-fine griseofulvin were almost twice that by an equal weight of standard griseofulvin. Clinical trials supported this implication.[3-6] The fact that the drug was efficacious and clinically potent in less than one-half the standard dose of griseofulvin led to a decision to examine the preparation from the standpoint of therapeutic efficacy as a single daily dosage in treating stubborn infections of the skin, hair, and nails.†

Since there were no previous clinical reports in the literature on the use of this preparation in the form of a single daily dose as a 500 mg. tablet, it was felt the study would be a worthwhile clinical undertaking.

Outline of Study

This study, therefore, attempted to determine the therapeutic efficacy of a single daily dosage in treating fungous infections of the skin, hair, and nails. Fifty patients of varied ages with the diagnoses of tinea capitis, tinea cruris, tinea corporis, tinea pedis, and onychomycosis were chosen. In order to establish the presence and subsequent disappearance of the organism, cultures for the examination of fungi were taken on Sabouraud's agar before and after treatment of lesions in all patients.

If the condition persisted beyond the expected period of treatment, another culture was taken. Treatment was continued until clinical and/or laboratory evidence indicated a definite response.

The criteria established for determining a response consisted of the following:

Excellent—complete clinical and laboratory cure

Good	—50% to 75% clinical cure
Fair	—25% to 50% clincial cure
Poor	—no clincial or laboratory response



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*Product of Schering Corporation, Bloomfield/Union, N.J.

†The Fulvicin-U/F was kindly supplied by the Medical Department of Schering Laboratories.



Fig. 1. **Finger nail before onset of treatment.**



Fig. 2. **Finger nail three months after onset of treatment.**

The study included eleven patients having onychomycosis, ten having tinea cruris, sixteen having tinea pedis, nine having tinea corporis, and four having tinea capitis.

The initial culture showed Trichophyton rubrum in thirty patients, T. mentagrophytes in four, E. floccosum in five, M. canis in three, and one in each of the following: T. tonsurans, Mucoraceae, and Streptomyces.

Although it is felt that every patient should have an identifiable organism cultured before being treated, there were five instances where initial cultures were negative or unobtainable; yet KOH preparations were positive. This is an expected response since, as so many physicians have found, there are always a few individuals where an organism cannot be identified yet the clinical eye and KOH scraping reveal a fungous infection.

Table I

RESULTS WITH SINGLE DAILY DOSAGE OF GRISEOFULVIN IN FUNGOUS DISEASES

DIAGNOSES:	Pts.
Tinea Cruris	10
Tinea Corporis	9
Tinea Pedis	16
Tinea Capitis	4
Onychomycosis	11
TOTAL (45 male; 5 female)	50

FINAL CULTURES:	
Negative	31
T. Rubrum	14
E. Floccosum	2
Contaminant	2
Streptomyces	1

INITIAL CULTURES:	Pts.
T. Rubrum	30
T. Mentagrophytes	4
E. Floccosum	5
Mucoraceae	1
Streptomyces	1
T. Tonsurans	1
M. Canis	3
KOH Positive, Culture Negative	5

DURATION OF TREATMENT:	
2- 7 weeks	34
8-10 weeks	9
11-25 weeks	7
(Overall average treatment: 52 days)	

SIDE EFFECTS:	
Diarrhea, 3-4 weeks	1*

RESULTS:	Pts.
Excellent	21
Good	21
Poor	4†
Fair	4†

*Patient also on phenobarbital and arthritic medication.
†One patient unreliable in taking medication in each category.

Table II
EFFECTIVENESS OF SINGLE DAILY DOSAGE OF GRISEOFULVIN IN TINEA CRURIS
(10 Patients; Ages 19-62)

Initial Culture:	Pts.	Final Culture:	Pts.
T. Rubrum	6	Negative	5
T. Mentagrophytes	1	E. Floccosum	2
E. Floccosum	3	T. Rubrum	2
		Contaminant	1

Duration of Treatment:	Pts.
2-6 weeks (Average, 25 days)	10
Results:	
Excellent	4
Good	5
Fair	1*
Poor	0
Side Effects	0

*Patient did not take medication as directed.

Table III
EFFECTIVENESS OF SINGLE DAILY DOSAGE OF GRISEOFULVIN IN TINEA CORPORIS
(9 Patients; Ages 18-49)

Initial Culture:	Pts.	Final Culture:	Pts.
T. Rubrum	6	Negative	9
Mucoraceae	1		
E. Floccosum	1		
Culture negative	1		

Duration of Treatment:	Pts.
2-8 weeks (Average, 41 days)	9
Results:	
Excellent	8
Good	0
Fair	1
Poor	0
Side Effects:	0

Results

Table I illustrates the diagnoses, initial and final cultures, duration of treatment, and results achieved for the overall study. Tables II through VI illustrate the cultures, duration of treatment, and results for each individual condition.

Good to excellent results were achieved with Fulvicin-U/F 500 mg. per day in nine out of ten patients (90%) with tinea cruris, eight of the nine patients (88%) with tinea corporis, fourteen of the sixteen patients (87%) with tinea pedis, and all of the patients with tinea capitis.

Of the eleven patients with onychomycosis, seven showed a good response; two showed a fair response. This could be considered a significant result in that onychomycosis often requires long-term therapy and sometimes fails to respond to any therapy at all. It is very likely that clinical cures would have been achieved if treatment had been continued for longer than the three month experimental period.

Figures 1-4 illustrate the clearing accomplished with this drug in onychomycosis over a three month period. The duration of treatment ranged from two to twenty-five weeks for the overall study with the shortest period of therapy in Tinea cruris (an average of twenty-five days) and the longest in onychomycosis (an average of ninety-two days).

The only side effect was diarrhea in one patient, which occurred after several weeks

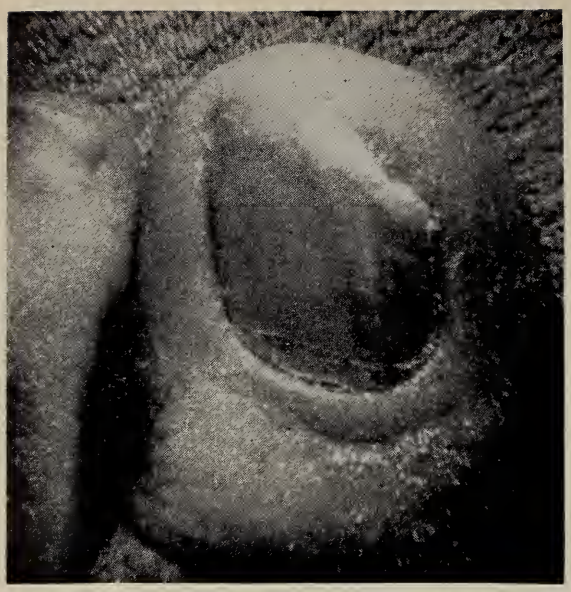


Fig. 3. **Toe nail before onset of treatment.**

of therapy. This same patient was also taking phenobarbital and medication for arthritis concomitantly.

Summary and Conclusions

A total of fifty patients with various types of fungous infections were treated with a single daily dosage of Fulvicin-U/F 500 mg. Good to excellent results were achieved in thirty-five of thirty-nine patients having tinea capitis, corporis, pedis, and cruris. Seven out of eleven patients having onychomycosis showed a good response.

On the basis of the clinical response, photographs, and laboratory results, one

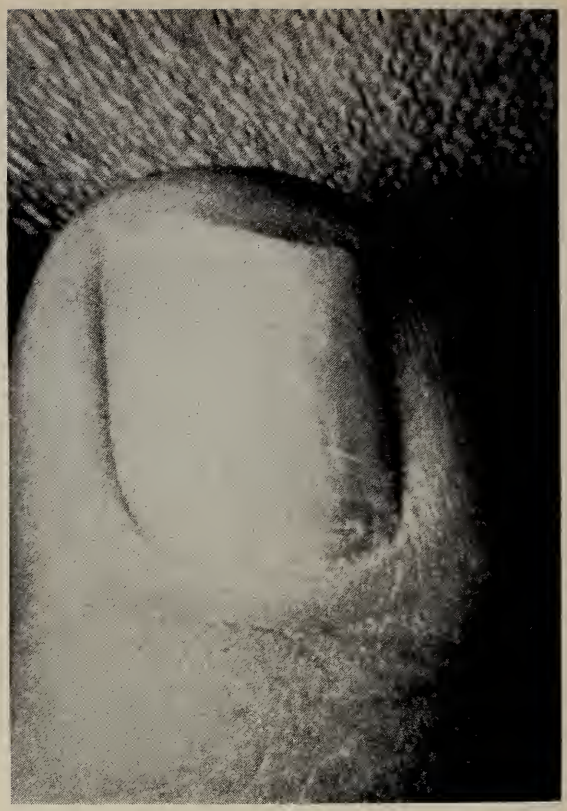


Fig. 4. **Toe nail three months after onset of treatment.**

Fulvicin-U/F 500 mg. tablet daily can be considered very effective therapy in fungous infections.

Therapeutic effectiveness, elimination of possible dosage error, and convenience of administration should make this preparation highly desirable to both physician and patient as an oral antifungal for once-a-day use.

Table IV

EFFECTIVENESS OF SINGLE DAILY DOSAGE OF GRISEOFULVIN IN TINEA PEDIS

(16 Patients; Ages 9-57)

Initial Culture:	Pts.	Final Culture:	Pts.
T. Rubrum	8	Negative	12
T. Mentagrophytes	3	T. Rubrum	3
Streptomyces	1	Streptomyces	1
E. Floccosum, T. Mentagrophytes	1		
Culture negative	3		

Duration of Treatment:	Pts.
4-11 weeks (Average, 52 days)	16
Results:	
Excellent	6
Good	8
Fair	0
Poor	2*
Side Effects:	
Diarrhea, 3-4 weeks	1†

*One patient unreliable in taking medication.
†Patient also on phenobarbital and arthritic medication.

Table V
EFFECTIVENESS OF SINGLE DAILY DOSAGE OF GRISEOFULVIN IN TINEA CAPITIS
(4 Patients; Ages 4-6)

Initial Culture:	Pts.	Final Culture:	Pts.
T. Tonsurans	1	Negative	3
M. Canis	3	Contaminant	1

Duration of Treatment:	Pts.
3-8 weeks (Average, 31 days)	4
Results:	
Excellent	3
Good	1
Fair	0
Poor	0
Side Effects:	0

Table VI
EFFECTIVENESS OF SINGLE DAILY DOSAGE OF GRISEOFULVIN IN ONYCHOMYCOSIS
(11 Patients; Ages 9-51)

Initial Culture:	Pts.	Final Culture:	Pts.
T. Rubrum	10	T. Rubrum	9
Culture Negative	1	Negative	2

Duration of Treatment:	Pts.
6-25 weeks (Average, 92 days)	11
Results:	
Excellent	0
Good	7
Fair	2
Poor	2
Side Effects:	0

References

1. Kraml, N.; Dubuc, J. and Beall, D.: Gastrointestinal Absorption of Griseofulvin: I. Effect of Particle Size, Addition of Surfactants, and Corn Oil on the Level of Griseofulvin in the Serum of Rats. *Canad. J. Biochem. & Physiol.* 40:1449-1451, 1962.
2. Kraml, M.; Dubuc, J. and Gaudry, R.: Gastrointestinal Absorption of Griseofulvin: II. Influence of Particle Size in Man. *Antibiotics* Chemother. 12:239-242, 1962.
3. Robinson, H.M. and Dunseath, W.R.: Micronized Grieseofulvin. *J. Invest. Dermat.* 39:65-66 (August) 1962.
4. Sullivan, F.J.: The Effectiveness of Ultrafine Griseofulvin. *Western Med.* 8:94-95 (March-April) 1967.
5. Bielinski, S. and Falk, A. B.: Griseofulvin U/F in Tinea Capitis. *Illinois M.J.* 125:624-625 (June) 1964.
6. Zelickson, A.S.: Lower Dosage with Ultrafine Griseofulvin. *Clin. Med.* 73:73-74 (August) 1966.

Rural Emergency Services

Complementing the five-point rural emergency medical services plan recently developed by the AMA's Council on Rural Health is its vital sequel—"Guidelines for Implementation. . . ."

This essential aid affords countless serviceable suggestions which no doubt will prove instrumental in achieving the desired results long sought by rural community leaders. Its four pages are brimming with ideas relative to organizational structure, mechanisms by which presently existing emergency systems may be evaluated and general recommendations with regard to first aid, communications and transportation. Single copies may be obtained—at no cost—from the Council on Rural Health, American Medical Association, 535 N. Dearborn St., Chicago, 60610.



KININS—A POTENT BIOLOGIC AGENT

Kinins are a group of polypeptides with all the properties necessary to induce an acute inflammatory process. These agents influence smooth muscle contraction, cause hypotension, increase capillary permeability, produce vasodilation, incite pain, and may also cause the emigration of granulocytic leukocytes. Their exact role in any biological system is not known but kinins are implicated in various forms of acute arthritis, gout, asthma, endotoxin shock, migraine headaches, and the acute inflammation associated with burns.

Kinins are split from kininogens by the proteolytic group of enzymes called kallikreins that are found in the pancreas, sweat and salivary glands, urine, plasma, intestines, and neutrophilic granulocytes. Bradykinin and kallidin were discovered many years ago. Wasp and snake venom contain many kinins. This is understandable because venom is a salivary secretion.

Kininases is the only specific anti-kinin and, as such, could be called an anti-inflammatory agent. On the other hand, kinin activity can be altered indirectly by depletion of kininogens or by the inhibition of any of the preceding enzymatic steps.

Kinins have been found in the inflammatory synovial fluids of those with gout and rheumatoid arthritis. The concentration of polypeptides is not correlated with the severity of symptoms or signs. The question is, what activates the kallikrein system? There is some evidence that the therapeutic effects of the salicylates, glucocorticoids, and colchicine is brought about because the products interfere with the kinin system. The evidence, however, is meager and from a practical side, we must search for agents that antagonize the kinins in order to reap the benefits of this interesting and exciting pharmacological finding.

T. R. Van Dellen, M.D.

References

1. Kinis and Arthritis. Alan S. Nies and Kenneth L. Melmon. Bulletin on the Rheumatic Diseases (Sept.) 1968; *19*:1; pgs. 512-516.
2. Kinins—Possible Physiologic and Pathologic Roles In Man. R.W. Kellermeyer and Richard C. Graham, Jr. New England Jl. of Med. (Oct. 3) 1968; *279*:14; pgs. 754-758.

Illinois has 122 institutions of higher education. Only three states have more colleges and universities. More students attend colleges in Illinois than in the United Kingdom, Sweden, Norway, and Denmark combined.

New Alcoholic Treatment Program Developed

A new alcoholism program based on the philosophy that alcoholism is a progressive disease which may be therapeutically interrupted at any point in its course is being carried out jointly by psychiatric personnel of the Loyola University Stritch School of Medicine and the Hines Veterans Administration Hospital.

The program requires that a prospective candidate sign a contract stipulating that he agrees to no privileges, no passes and no visitors for a hospitilization period up to six weeks, as the first step in his rehabilitation process.

This approach is designed to accelerate the alcoholic's involvement in the inpatient treatment process. It is in sharp contrast to permissive treatment programs which allow passes, privileges and visitors, and reportedly "lose" 15 to 25 per cent of their patients via premature discharges and drinking while on home visits.

While an inpatient at Hines, the patient is exposed to a broad spectrum of treatment methods including drug therapy, group therapy (both traditional and by married couples), family therapy, Alcoholics Anonymous and occupational therapy.

Since alcoholics represent a variety of personality disorders, an attempt is made to tailor the treatment as much as possible. For example, a number of alcoholics seem to respond very well to the combination of Antabuse (a drug which produces a toxic reaction if there is any alcohol in an individual's bloodstream) and Married Couples Group Therapy, whereas others seem to benefit more from Alcoholics Anonymous.

Upon discharge, the patient is encouraged to continue treatment at either the Loyola Clinic in the John J. Madden Mental Health Center or newly formed Hines PHC (Post-Hospital Care) Clinic. In addition, program graduates are urged to continue their use of Antabuse (as a preventative measure) and their involvement with Alcoholics Anonymous groups in their communities.

Thus far the Loyola-Hines program has admitted more than 120 patients during its first eight months of operation. There has been no drinking on the ward and only four premature discharges. Of the first 100 men discharged, the readmission rate has been 14 per cent while the sobriety rate has been 78 per cent.

Plans are underway for the establishment of a Halfway House at Hines and increased involvement with industrial firms in nearby communities.

Criteria for admission to the program: The patient must be a U.S. veteran, male, under 50, residing within 50 miles of Hines, without decompensating physical illnesses and able and willing to accept the contract stipulation of no privileges, no passes and no visitors for a period of up to six weeks.

New Medical Schools

Five more institutions have joined the United States medical school ranks this fall, bringing the total of such institutions to 99.

Opening the door for the first time to freshman classes are the University of California School of Medicine at Davis, the University of California San Diego School of Medicine, the University of Connecticut School of Medicine in Hartford, the Mt. Sinai School of Medicine of the City University of New York and the University of Texas Medical School at San Antonio.

First year classes at the five new medical schools are expected to range in size from 16 students at the University of Connecticut Medical School to 56 students at the University of Texas in San Antonio. Both new University of California medical schools expect a first year enrollment of around 50 students each, while 25 students are expected to comprise the first year class of the Mt. Sinai School of Medicine in New York.

This year's total medical school enrollment is expected to be about 9,600 in comparison to last year's enrollment which totaled approximately 9,400.

IDPA

Illinois Department of Public Aid

Payment Procedures and Policies Explained

Harold O. Swank, Director
Illinois Department of Public Aid

Part II of a Series.

The first article of this series explained the Medical Assistance program under Title XIX and the direct payment of physicians for medical charges which are usual, customary, reasonable and prevailing.

The first installment ended with a listing of the questions most frequently asked by physicians. Since there were a number of questions asked, **DOES THIS MEAN DOCTORS DO NOT UNDERSTAND THE PROGRAM?**

No. Most doctors understand the program and experience no difficulty in receiving their payments. However, there continues to be a sizeable number of billing errors which do cause delays in payment. Any bill which cannot be computer processed requires manual handling or individual consideration. In either case, a delay ensues which may vary from three to eight weeks depending on the nature of the error. The normal processing period —from the date the bill is received to the date the payment is mailed—is about forty-five days.

HAVE YOU A QUESTION?

Physicians' questions concerning IDPA methods, procedures and policies are solicited and will be answered in these articles or by direct communication. The Department is desirous of eliminating misunderstandings and to work cooperatively with Illinois physicians. Send questions to:

IDPA Editor
Illinois State Medical Society
360 N. Michigan Avenue
Chicago, Illinois 60601

DO MANY BILLS REQUIRE INDIVIDUAL CONSIDERATION?

The number is sizeable. For instance, 102,695 physicians' bills were processed in July, 1968, and of these, 17,366—or about 16.9 percent—required such handling. Case identification errors require a manual and/or machine check of records and sometimes the help of county staff. Some errors of medical procedure can be checked by IDPA but some need consultation. All, however, slow the processing and payment of bills.

The 17,366 rejected bills subdivided into 11,419 involving some phase of case identification and 2,657 involving some medical procedure. Case identification data include case number, case eligibility and patient's name. Causes of medical procedure rejects include multiple coding which the computer is not programmed to handle and procedures involving alternatives for which there is inadequate coding, or no coding, in AMA's Current Procedural Terminology booklet. Some procedures—for instance, consultations—are automatically selected out for individual consideration because it isn't worthwhile to go to the programming breadth necessary to handle them.

IS IT REALLY NECESSARY THAT PHYSICIANS' BILLS BE COMPUTER PROCESSED?

Yes. IDPA processes more than 600,000 medical bills of all types each month, including some 102,000 physicians' bills. It is impractical not to use machines to the utmost.

DOESN'T DATA PROCESSING ADD TO THE DOCTORS' "PAPERWORK"?

It isn't a question of extra work but rather a matter of extra precision in writing up the billing. There is little difference in the content of a physician's bill for services rendered a public aid recipient and for his services rendered a patient with health insurance coverage. Both types of billing require case identification to include name, age and address of the patient, name and address of the head of the household if patient is a dependent, name of the administering physician, a description of the medical procedure rendered, and the charges.

IF THERE IS THAT MUCH SIMILARITY, THEN WHY ARE THERE SO MANY ERRORS?

As said earlier, it is a question of *precision*. First, let's consider the question from the standpoint of the computer. The profile of each active public aid case is stored on tape and placed at the disposal of the computer. The intent is that every physician's bill pertaining to a particular profile be referred to that profile and to no other. To accomplish this, each person eligible for medical assistance is issued an identification card which contains, among other things, a case identification number, a group or county number, the case name (person to whom the card is issued) and names of all other eligible persons in the case.

Proper identification of the case, though simple, cannot be overstressed. The doctor merely transfers the information from the recipient's case identification card to the comparable spaces at the top of the billing Form 132. First he should check the first block of the case identification data to make sure the card (hence eligibility) has not expired. The patient's name must appear on the card either as the person to whom the card was issued or in the separate block where other eligible family members are listed.

The doctor should copy the case number exactly as it identifies the profile stored in the computer . . . and no other. The group or county number must be exact as it identifies the geographical location of the case. Copy the first and last names of the person to whom the CID card is issued—do not abbreviate or use a nickname; for instance, don't write down Bobby if the name is Robert. The computer cannot make such fine distinction. The patient's name should also be copied verbatim—for the same reason. Sometimes the name of the person to whom the CID card is issued is also the patient but at other times the patient may be another person in the household. In either situation, always enter the patient's name. The birth date of the patient must also be recorded and the physician's AMA medical education number should be typed, stamped or printed in the appropriate box.

Upon arrival in Springfield, the bill is coded on a punched card and fed to the computer which simply matches the identification number of the bill with the identification of the stored profile. If they match, the subsequent action is swift and unerring but if there is a mismatch of any kind, the bill is rejected for manual handling.

WHAT IF THE IDENTIFICATION DATA ARE CORRECT BUT THERE IS AN ERROR IN MEDICAL PROCEDURE?

Most medical procedures are programmed into the computer's stored or memory system as are also the usual, customary, reasonable and prevailing physicians' fees. If the procedure is coded properly—as described in AMA's Current Procedural Terminology booklet—the computer processes it, computes payment, and prints out all data it was programmed to do. If there is an error in medical procedure, the computer rejects the bill after which it must receive individual consideration from professional staff.

IS THE CURRENT PROCEDURAL TERMINOLOGY IN NEED OF REVISION?

Yes, it is inadequate in many areas. Some procedures are not coded at all and in some the possible alternatives are not spelled out. Even though a great effort went into delineating medical procedures and assigning codes, the CPT was published with the certain knowledge that experience would disclose inadequacies. It is IDPA's understanding that the AMA is revising the CPT but no publication date has been forecast.

(Continued on page 824)

The Perils of Immobility

A First-person Case Report

By Jane Jeffris, R.N./Chicago

Although polio is considered a conquered infectious disease, there were 93 cases of paralytic polio in the United States in 1966. And then, there are the severely paralyzed victims from other years. According to the National Foundation there are approximately 1,800 patients in the U.S. who use respiratory equipment for survival. These people are paraplegics or quadriplegics with residual paralysis of the respiratory muscles, and they present a multiplicity of problems for the medical profession.

My story, while unique in some respects, may be used as a guideline in treating other patients. Whether the person is handicapped from polio, multiple sclerosis, spinal cord injury or any other disease which causes immobility and/or a breathing deficit, special precautions should be taken.

I have been a quadriplegic polio for fifteen years. My vital capacity, while supine, is 875 c.c. and my activities are quite limited. I spend most of my life on a rocking bed in order to get air. Despite this, I have been able to accomplish my goal of helping myself, my family and my community. However, any intercurrent illness, if severe, complicates my life and causes me great anxiety.

Case Report

The episode that I am reporting here began like appendicitis, with low abdominal pain and cramps, followed by nausea, vomiting and fever. My white blood count was 16,500 with polymorphonuclears 86, and lymphocytes 14. There was diffuse rigidity of the lower abdomen.

A plain film of the abdomen was startling—I was quizzed intensively as to whether I had swallowed an object, or had an enema or douche lately. There was a radiopaque shadow, 5 cm. in diameter, low in the abdominal cavity. The answers to all the questions were negative. I had not swallowed anything, nor had I had an enema or douche. It seemed incredible and frightening that an object could be in my abdomen without my knowing it.

Additional films were taken from several angles. As in the previous films the mysterious shadow was definitely there.

The surgeon did a vaginal exam and couldn't locate anything there. He then did a rectal and found the mysterious object. With some manipulation and a great deal of pain he was able to remove this rock-like formation, which was approximately 2 inches in size. It was found to be composed of barium sulfate. The year before I had been treated for a duodenal ulcer, and at that time I had a complete GI series.

Now, most people ask: "Didn't you have any symptoms during those twelve months? Yes, I had symptoms throughout that time—low abdominal pain, at times cramps, and a copious amount of mucous

in the stools; however since I also had emotional problems it was thought to be the usual type of functional colitis.

After the barium was removed the symptoms continued. It was felt that a perforation, with associated lower abdominal inflammatory process, now existed. I was a poor candidate for surgery. My doctors decided to use conservative treatment.

Intravenous fluids, which were started on hospital admission, were continued through the next five days. A rectal tube was inserted for the gas which I couldn't expel. No medication was given for pain because peristalsis was already nil and narcotics depress peristalsis in the colon. My two doctors watched me far into the night, debating the possibility of doing surgery.

The next morning a proctoscopic examination and Gastrografin visualization of the lower colon were done. In addition a Miller-Abbott tube was passed from above to relieve distention.

During that second day in the hospital my breathing grew worse, due to the pain, the abdominal distention, and the increased oxygen demand occasioned by fever. The motion of the rocking bed in conjunction with the rectal tube rubbing up and down caused such severe pain I couldn't tolerate it; but without rocking I couldn't get enough air. The only solution seemed to be the tank respirator, which seemed like a disaster to me. As it turned out, that one night in the tank respirator enabled me to get more air with less pain, and brought the first rest in forty-eight hours.

This second night I was put into the intensive care unit, which is a benefit to any critical patient, especially the respiratory polio. Again, my doctors watched over me until after midnight and in addition they called in an otolaryngologist in case a tracheostomy should be required.

By the third day my abdomen became less sore and the distention decreased. The rectal tube was removed and I was able to rock again. Naso-gastric suction and intravenous fluids were continued until the fifth day when I was able to take liquids without vomiting. Temperature elevation continued for two weeks, ranging from F. 104° to 100.4°, despite antibiotics.

During the two weeks I ran a fever the doctors felt I had developed a pelvic abscess. While they considered an attempt to aspirate the abscess, it drained spontaneously into the rectum, with only mild diarrhea. My temperature dropped to normal and recovery thereafter was uneventful.

Comment

Respiratory polios, as well as all others who are immobile, present a challenge to the medical profession when intercurrent problems supervene. The liklihood of pneumonia, atelectasis and thrombophlebitis are increased.[1] The paralyzed or elderly patient is most vulnerable. Keeping a patent airway and a tidal exchange sufficient to meet increased demands is of critical importance with these patients. I found that positive pressure via a face mask for five minutes, several times a day, as recommended by the anesthesiologist, was a great help during those days of fever and dyspnea. I believe an inhalation therapy team is one of the greatest boons to the respiratory problem patient in recent years by lending much needed reassurance to both patient and doctor.

As for the barium being retained for so many months after the X-rays, I have found nothing in the literature to equal it. Vulkmer and Trummer record a case of barium appendicitis in a 43-year-old man 12 days after a barium study of the colon.[2] Seaman and Wells, in their article "Complications of the Barium Enema," report cases of perforation and leakage of colonic contents during the diagnostic enema, but they do not mention barioliths of this type.[3]

Summary

With the immobile patient, keeping the administration of barium for just the extreme case is desirable, but not always possible. The use of other types of contrast media might be considered. If barium must be used, then a scout roentgenogram should be done a week or two after the barium study in order to get an "all-clear."

References

1. Asher, Richard A. J., Dangers of going to bed. British Medical Journal, 2:967-968, Dec. 13, 1947.
2. Vulkmer, George J. and Trummer, Max J., Barium appendicitis. Archives of Surgery, 91:630-632, Oct. 1965.
3. Seaman, William B. and Well, Josephine, Complications of the barium enema. Gastroenterology, 48:728-736, June 1965.

AMA Urges Cooperation of Physicians in Comprehensive Health Planning

Following the enactment of the Comprehensive Health Planning Act (Public Law 89-749) in November, 1966, the House of Delegates of the American Medical Association adopted a report which defined the role of the medical profession in comprehensive health planning and urged state and local medical societies to participate vigorously in the program. It concluded that planning, organization, and distribution of health facilities and services are a prime responsibility of organized medicine.

Along these same lines, the AMA Council on Rural Health and its Advisory Committee agreed upon the following observations regarding community health planning during a recent meeting held in Chicago:

a) Present resources to aid in community health planning include the Comprehensive Health Planning Act, Public Law 89-749, regional medical programs, and inherent community resources such as current health programs, health facilities and personnel and recognized planning groups.

b) The need for community health planning in rural areas is urgent because of the maldistribution of health manpower, limited health facilities in sparsely populated areas, duplication of agencies and programs, and inefficient utilization of health manpower and facilities.

c) There is need for development of innovative ways to utilize present health manpower.

d) The health team approach with its use of allied health professionals to assist the physician will expand the availability of health services in many rural areas.

e) The role of national organizations concerned with the health of the rural population should be defined, and effective communication established, with respect to rural community health planning.

f) Task forces on comprehensive health planning should establish a structure to deal effectively with the rural sector of the population.

g) Resources should be made available for development of local or area planning councils to help in the development of planning for the sparsely populated rural areas.

The Council on Rural Health is prepared to provide information and advice to rural groups interested in becoming actively involved in the vital area of health planning. Inquiries should be directed to the Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Psychology Courses for Medical Students

In efforts to better equip today's medical student with more tools to treat non-medical problems, the University of Illinois Graduate College has initiated a curriculum in medical psychology leading to a master's degree.

"There are no similar programs in the state or outside of Illinois," says Dr. Milan V. Novak, associate dean of the University's Graduate College at the Medical Center Campus, Chicago.

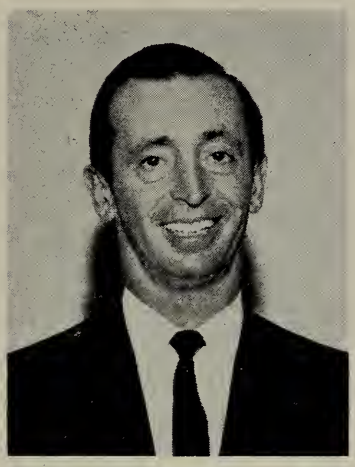
This is a pioneer undertaking made possible by the faculty and research facilities in the Department of Psychiatry. Candidates must meet the admission requirements of the Graduate College at the Medical Center.

Advanced training in scientific investigation of emotional illness and health will be the focus of the graduate program. Studies will include: the theories of development of emotional disorders; the models and concepts used to organize an understanding of biological, personal, and social factors involved; and the methodological and statistical tools necessary for designing and conducting research studies in this area.

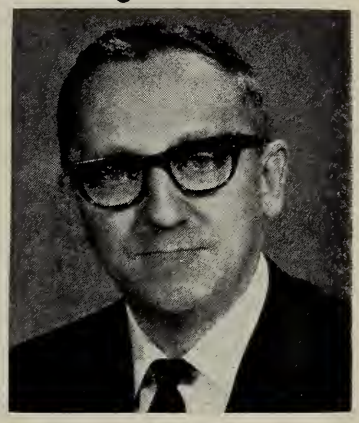
Illinois has over 130,000 farms averaging 228 acres each, supporting more than 40 different crops. Its farms are valued at $13 billion.

MEMBERSHIP SURVEY RESULTS:

What You Said . . .
What ISMS Is Doing



Dr. Frank J. Jirka, Jr., chairman of ISMS Board of Trustees, which authorized membership survey.



Dr. Matthew B. Eisele, chairman, ISMS Committee on Public Relations.

Part II: SOCIO/ECONOMIC Issues

THIS MONTH we tell you *what you collectively told us* on these key socio-economic issues—

Relative adequacy of Medicare and public-aid payments . . .
Short-term steps to ease the M.D. shortage . . .
Local authority in Comprehensive Health Planning . . .
Alternatives to the expansion of Medicare . . .
The welfare problem.

On these issues we tell you the results of the August membership survey . . . background information . . . and the action that the ISMS leadership is taking in response to your opinion.

Last month we similarly treated survey questions of a Legislative and Legal nature.

In January, we'll cover issues involving Professional Practice. Your reactions on these will be guiding us on such matters as midweek off-day schedules . . . a 7-day hospital week . . . health-care costs . . . and our relations with hospitals and paramedical groups.

While elated by the responses from some 3,000 of you, we realize that any survey—no matter how carefully prepared or well received—has certain limitations.

We are aware that on such complex topics, our questions—and your checkmarks—could not always convey the full message.

Such qualifications aside, the survey has been invaluable in advising your ISMS leadership of your views and wants. You have given us plenty of grist for our mills.

As these articles point out, your leaders are acting in response to your views . . . the mills are grinding.

Matthew B. Eisele, M.D.

MATTHEW B. EISELE, M.D.
Chairman, Committee on Public Relations

ADEQUACY OF MEDICARE AND PUBLIC AID FEES?

QUESTION AND GENERAL RESPONSE:

Controversy exists over Medicare and Illinois Department of Public Aid payments, and disparities between them.

	% of M.D.'s in FAVOR
a. If you accept assignments under Medicare, are you generally satisfied with the amounts you are paid by the fiscal intermediary?	67%
b. If you treat public-aid recipients, are you generally satisfied with:	
Payments from IDPA for patients covered by both Medicare and public aid?	46%
Payments from IDPA for non-Medicare patients?	37%

BREAKDOWN:



a. b.

a. Generally satisfied with amounts paid under Medicare by fiscal intermediary, 67%. b. Not satisfied by payments from IDPA for non-Medicare patients, 63%.

About 72 per cent of the responding physicians answered on Medicare, and about two-thirds on public aid.

One of the chief findings is that while specialists are more satisfied with Medicare payments than are general practitioners, the reverse is true with non-Medicare payments. Here is the overall breakdown:

	MEDICARE	COMBINATION MEDICARE/ PUBLIC AID	NON-MEDICARE
By age:			
Under 40	65%	44%	36%
40-55	68%	45%	35%
Over 55	65%	49%	41%
By area:			
Chicago Med. Society	67%	48%	39%
Downstate	67%	45%	36%
By field of practice:			
General practitioners	63%	42%	40%
Specialists	69%	48%	36%
By type of practice:			
Solo practice	64%	43%	37%
Partnership or group	70%	47%	34%
Hospital-based	72%	57%	47%

BACKGROUND:

Medicare—which took effect in mid-1966—provided for payment of physicians on the basis of reasonable charges. These take into consideration "the customary charge for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services."

From 1958 until 1967, fees for treatment of public-aid cases were paid on a flat-rate basis which IDPA Director Harold O. Swank readily admitted was unrealistic.

A new IDPA fee formula—reached with ISMS—took effect in January, 1967. Modeled on Medicare fee principles, it employs "usual," "customary" and "reasonable" criteria, as follows:

USUAL

The "usual" fee is that fee usually charged for a given service, by an INDIVIDUAL physician to his private patient (i.e., his own usual fee).

CUSTOMARY

A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county).

REASONABLE

A fee is "reasonable" when it meets the above two criteria, or in the opinion of the responsible local, district, or state medical society review committee, is justifiable, considering the special circumstances of the particular case in question.

To determine the fee pattern in each county for various medical procedures, the ISMS sent its membership a questionnaire on their 1966 charges. More than 60 per cent of the questionnaires were completed and returned.

While comparable in principle, Medicare and public-aid payments follow these differences in practice:

1. "In Medicare, the carriers have an open-end appropriation, but our monies are tied to biennial legislative appropriations," remarked Robert G. Wessel, IDPA chief of medical administration.

2. Under Medicare, the carriers recognize higher fees for specialists, within the customary and prevailing limits. "But in IDPA we pay on the basis of the procedure, whether administered by a general practitioner or a specialist," said Wessel.

3. The Medicare carriers can make individual fee adjustments, provided these do not exceed the prevailing rates. "But in IDPA we cannot consider any individual escalation of fees," said Wessel. "Any increase has to be statewide for the procedures involved."

Wessel quoted a 1967 statement on this point: "The Department will consider unreasonable any escalation of fees above the current levels unless this escalation follows agreement between the ISMS House of Delegates and the Department."

Despite the disparities with Medicare, IDPA officials believe their fee formula has accomplished its primary aims of: (1) assuring more realistic payments, and (2) encouraging more physicians to participate in public aid, notably in areas where there are large concentrations of public-aid cases but few doctors.

Payments for treatment of public-aid recipients have more than doubled since adoption of the fee schedule, Dr. Henry A. Holle, IDPA medical director, recently noted. The number of participating M.D.'s rose from 3,228 in June, 1967, to 5,554 last March.

"The fees are much better than they have been," remarked Dr. Joseph R. O'Donnell, chairman of the ISMS Committee on Usual and Customary Fees. "I think the physicians' dissatisfaction results primarily from delay in the payment of fees that the Department questions, and lack of ability to communicate with IDPA."

ACTION TO BE TAKEN:

The Board of Trustees referred the survey response to the Committee on Usual and Customary Fees.

Dr. Philip G. Thomsen, ISMS president and immediate past chairman of that committee, has indicated that a comprehensive review of the public-aid fee program will be sought. He has called for adjustments in the fees paid specialists.

Also, ISMS is taking steps to promote greater understanding between physicians and IDPA. It is urging all county medical societies to form review committees to help doctors in their dealings with the agency. It is holding workshops on public aid, Medicare and other government health programs to familiarize M.D.'s and their assistants with proper claim procedures.

ALTERNATIVES TO EXPANDED MEDICARE?

QUESTION AND GENERAL RESPONSE:

Fearing the Federal Government will expand its health insurance beyond Medicare, some observers call for steps to amplify private insurance coverage. Would you favor:

	% of M.D.s in FAVOR
a. Legislation requiring all employers to provide health insurance—through private carriers—to all employees and their families?	55%
b. Graduated rebates on federal income taxes to help persons under 65 buy broader health-insurance coverage?	85%

BREAKDOWN:

The only marked differences appeared in the inquiry on mandatory company-furnished health insurance, as follows:

By area:	
Chicago Medical Society	59%
Downstate	50%
By type of practice:	
Solo practice	55%
Partnership or group	54%
Hospital-based	60%

BACKGROUND:

A committee of the AMA has noted that while 80 per cent of the U. S. public has some form of health insurance, the benefits pay only a third of health-care bills. The patient generally has to make up the difference.

As an answer to the problem of health-care bills, President Johnson has urged extension of Medicare to certain groups under 65.

Some observers believe mandatory coverage by employers would be a most direct way to strengthen and extend the benefits. However, the question has arisen: Can physicians advocate compulsion of private corporations while insisting on freedom for themselves?

An alternative to compulsory plans was offered by the AMA Council on Medical Service last June. Under this proposal, lower-income people under 65 would get credits on federal income taxes to help them buy fuller health-insurance protection. The rebates would be graduated according to ability to pay. If someone earned too little to be liable for taxes, the government would issue him a voucher to buy adequate insurance. Private companies and prepayment carriers would issue the policies.

ACTION TO BE TAKEN:

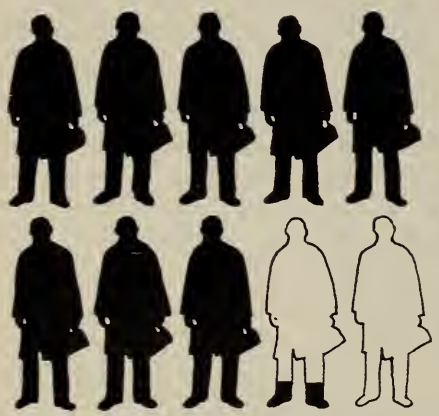
The Board of Trustees referred the survey response on this issue to the Council on Legislation and Public Affairs and the Council on Medical Service for study and recommendations. ISMS support of the rebate proposal would strengthen any effort by the AMA to implement it in Washington.

ACTION AGAINST PHYSICIAN SHORTAGE?

QUESTION AND GENERAL RESPONSE:

To meet the physician shortage on a short-term basis, would you favor any of the following steps:

	% of M.D.s in FAVOR
a. An accelerated inflow of foreign doctors, provided they meet state qualifications?	36%
b. Programs to help Americans get undergraduate medical training abroad until U. S. facilities are sufficient—provided the student returns to this country for postgraduate study and licensure?	56%
c. Government grants to newly graduated physicians who agree to practice a certain number of years in medically deficient areas?	81%
d. More intensive action by medicine and hospitals to sponsor and coordinate health facilities in deficient areas?	93%



81% of Illinois' physicians favor government grants to newly graduated physicians who agree to practice in medically deficient areas.



93% of Illinois' physicians would like to see more intensive action by medicine and hospitals in sponsoring and coordinating health facilities in deficient areas.

BREAKDOWN:

Generally the only marked differences were by area as follows:

	More Foreign M.D.s	Foreign Study Programs	Grants for Needy-Area Practice	M.D./ Hospital Cooperation
Chicago Medical Society	38%	61%	85%	95%
Downstate	35%	51%	76%	92%

On one question—foreign medical-study programs for U. S. students—the age categories differed as follows:

	% of M.D.s in FAVOR
Under 40	47%
40 - 55	54%
Over 55	64%

BACKGROUND:

a. Increasingly many physicians have been brought from abroad to ease the U. S. shortage. The foreign-born account for more than one-tenth of the U. S. total. Some 12,000 of them are serving as residents and interns in American hospitals. Controversy exists on this point: Will America's strict standards be diluted by continued heavy reliance on imported M.D.'s, particularly those from underdeveloped and "developing" countries?

b. U. S. medical schools each year reject about half their 18,000 applicants. In the eyes of many observers, a high proportion of the "rejects" are capable students, unfairly victimized by the lack of openings. These observers call for formalized programs and incentives to enable more such students to get their undergraduate medical training overseas. At present "perhaps 400" Americans a year enter European schools of medicine, according to an AMA report last year. The ISMS has been keenly interested in the domestic growth of physician training. Its House of Delegates last May called for state legislation to provide per-student subsidies to Illinois medical schools; the Board of Trustees in 1966 held that a med school was needed Downstate.

c. A North Carolina medical educator recently proposed that the Government give new physicians $100,000 tax-free for working five years in care-pinched rural areas. A Massachusetts internist commented: "But why limit it to rural poverty areas? The urban poor, sometimes almost in the shadow of the big reaching centers, often seem to fare even worse in the realm of day-to-day medical care." The North Carolinian's proposal—and the comment—appeared in last June's issue of Medical Economics.

d. Medicine and hospitals could cooperate in different ways to create and coordinate health facilities in deprived areas. Three ideas are: (1) cooperation through voluntary areawide or local planning; (2) establishment of community health centers with Office of Economic Opportunity or private funding; (3) use of mobile units or comparable methods to extend services into medically needy communities.

ACTION TO BE TAKEN:

The Board of Trustees referred the survey responses on questions "a" and "b" to the Council on Medical Education, and on "c" and "d" to the Council on Legislation and Public Affairs. The responses will guide these councils in making recommendations on health manpower and medical education in Illinois.

CURTAILMENT OF WELFARE?

QUESTION AND GENERAL RESPONSE:

Should the medical profession take a basic stand against welfare programs and urge steps that would enable the federal, state and local governments to curtail them?	% of M.D.s in FAVOR 65%

If "yes," would you favor any of these approaches:

a. A guaranteed annual income to provide an economic floor for each family?	17%
b. A guaranteed annual work plan, so that each employable family breadwinner can earn $3,200 a year?	82%
c. Government-backed private loans to encourage qualified residents of deprived areas to develop their own enterprises and opportunities?	83%

BREAKDOWN:

The most interesting differences occurred on the basic question: Should the medical profession take a stand against welfare and urge alternatives? On this question, the divisions were appreciable in these membership categories:

By area:	
Chicago Medical Society	60%
Downstate	70%
By field of practice:	
General practitioners	74%
Specialists	60%
By type of practice:	
Solo practice	66%
Partnership or group	66%
Hospital-based	51%

On the three alternatives to welfare, Chicago Medical Society members responded more favorably than downstate members by several percentage points.

BACKGROUND:

The National Advisory Commission on Civil Disorders —popularly known as the Kerner Commission—challenged the present welfare system in its report.

It observed that the setup "contributes materially to the tensions and social disorganization that have led to civil disorders. The failures of the system alienate the taxpayers who support it, the social workers who administer it, and the poor who depend on it."

Public figures and economists have advanced several alternatives to welfare.

The idea of a guaranteed minimum *income* calls for assuring every family at least $3,200 a year—the government making up the difference if the family earns less than this. Fifty-eight per cent of the general public—including 45 per cent of those making under $3,000 a year—opposes the idea, according to the Gallup Poll.

However, that poll found 78 per cent of the people favoring the proposal for a guaranteed annual *WORK* plan.

The proposal for government-backed private loans to encourage enterprise among the poor is related to what President-elect Richard M. Nixon calls "black capitalism." It crosses party lines, however. The late Sen. Robert F. Kennedy wanted steps to "promote the ownership of retail, commercial and industrial enterprise by members of disadvantaged minority groups and residents of poverty areas."

ACTION TO BE TAKEN:

The Board of Trustees referred the survey results on these questions to the Council on Legislation and Public Affairs. The council's recommendations could guide the House of Delegates in urging appropriate action at the state level or by AMA at the national level.

LOCAL CONTROL OF COMPREHENSIVE PLANNING?

QUESTION AND GENERAL RESPONSE:

In the development of Comprehensive Health Planning programs, should the initiative and decision-making rest primarily with local rather than state or area bodies?

% of M.D.s in FAVOR
72%



The initiative and decision-making in the development of Comprehensive Health Planning programs should rest primarily with local agencies, according to 72% of Illinois' physicians.

BREAKDOWN:

The only marked differences were in these two categories:

By field of practice:	
General practice	79%
Specialty	69%
By type of practice:	
Solo practice	76%
Partnership or group	70%
Hospital-based	59%

BACKGROUND:

The question has arisen: Can Comprehensive Health Planning achieve its stated aims without subordinating local authority to the state agencies and areawide councils?

The U. S. Surgeon General said CHP "does not represent the imposition of a Master Plan by government upon the people." A CHP official, Dr. James H. Cavanaugh, said it "is not intended to replace existing decision-making processes."

On the other hand, another element in the Government "places little credence in the vitality or effectiveness of local initiative and decisions on health planning," the AMA Council of Medical Service asserted.

The AMA House of Delegates last June concurred in this council's plea "for continued efforts to preserve local initiative in health planning."

ACTION TO BE TAKEN:

The ISMS Board of Trustees is interested in keeping Comprehensive Health Planning on a voluntary basis that would safeguard local prerogatives. Seeking specific recommendations on the issue, it referred the survey response to the society's Council on Legislation and Public Affairs and Council on Medical Service.

IN THE JANUARY ISSUE OF IMJ:

Membership Survey Analysis on **PROFESSIONAL PRACTICE ISSUES.**

Adolescent Disk

Because a lesion of the lumbar intervertebral disk at L_{4-5} or L_5-S_1 is usually assumed to occur after 30 years of age, this diagnosis is infrequently made in the adolescent. Ten cases of disk herniation in such patients recently treated by us are reviewed. Our experience has led us to differ with other authors in the following respects. Except that trauma is a predominant cause, the clinical picture of lumbar disk herniation in the adolescent is identical with that in the adult. Since cord tumor is a more frequent source of the typical symptoms than is disk herniation in the young, we recommend early myelography for this age group. While a trial of conservative therapy may be useful, our results suggest that earlier surgical excision will lead to recovery in a greater number and will produce much less morbidity in the adolescent than in the adult group. (Sanford R. Weiss and Robert Raskind. The Teen-Age "Lumbar Disk Syndrome." International Surgery [June] 1968; **49**:6; pg. 531.)

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the Journal is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

KNOX COUNTY: Manquon; population: 400. Town without a physician for many years. Last physician practiced here for 60 years. Nearest physician 12 miles; nearest hospitals at Galesburg, 17 miles. Combined office and home available if desired. Agricultural community. Methodist Church. Grade and junior high schools; bus service to high school at Fairview. Nearest recreational facilities at Galesburg. For further information contact:

Mr. Walter Platt, Township Supervisor
Mrs. Gene Strode;
Mrs. H. D. Sulteen;
Mrs. Ira Moats; or
Mr. W. L. Shaffer, Maquon

KNOX COUNTY: Oneida; population: 700. Town without a physician since 1954. Nearest physician 10 miles; nearest hospitals at Galesburg, 13 miles, Peoria, 50 miles. Quad-cities, 50 miles. Office space available. Predominant nationality is Swedish. Agricultural area. Churches: Methodist, Presbyterian. Grade and high schools. Swimming and golf facilities within 14 miles. Located on route 34 and main line of CB&Q Railroad. For further information contact: President of Lions Club or Anderson State Bank, Oneida. Phone: 309-483-2341.

LASALLE COUNTY: Lostant; population: 500. Several small towns in trade area without physicians. Nearest physician, 5 miles; nearest hospital at Peru, 16 miles; 50 miles from Peoria. Office space available. Houses for rent and for sale. Financial assistance could be arranged. Predominant nationality is German. Source of income: agriculture, industry. Churches: Methodist, Catholic. Grade and high schools. Four hospitals within 18 miles. Nearest college, 12 miles. For further information contact: Mr. Guy Placker, Lostant.

LASALLE COUNTY: Mendota; population: 6700. Trade area, 24,000. Practicing physicians, 5, Mendota Community Hospital, 70 beds, 50 miles from Rockford. Three prescription drug stores. Predominant nationality is German. Sources of income: agriculture, industry. Churches: Eleven Catholic and Protestant. Grade and high schools. Nine hole golf course. New swimming pool and tennis courts. Rapidly expanding industries in area. For further information contact:

J. F. Wacker, M.D.,
1404 W. Washington St., Mendota
Phone: 2149

LASALLE COUNTY: Oglesby; population: 4,000. Only one physician—town formerly supported 4. Nearest hospital at La-Salle, 5 miles, 89 miles from Peoria, 65 miles from Rockford. Two local drug stores. Available office space includes reception room, office, 2 examining rooms, library, store room and lab. Predominant nationality is Italian. Sources of income: agriculture, cement mills and small industry. Churches: Catholic, Union, Baptist. Grade and high schools and Junior College. Two nearby country clubs, recreation center and bowling alley. Active Rotary Club. Chicago, 100 miles, Starved Rock, 3 miles. For further information contact: Mrs. John Rock at TU-3-8257.

LASALLE COUNTY: Seneca; population: 1,800; trade area, 3,000. Office building built to serve two physicians. Physician could do his own surgery and obstetrics. One physician in community. Nearest hospital at Ottawa, 15 miles, 114 beds. Sources of income: agriculture, explosives factory and oil processing plant. Churches: Catholic, Protestant. Nearby country club. For further information contact: T. F. Mullen, M. D., Seneca 61360.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Modified Wording Asked in IDPA/ Physician Agreements

ISMS will ask the Illinois Department of Public Aid to modify a proposed agreement to be signed by all physicians treating public-aid patients. Agreements are required under a 1967 amendment to the Social Security Act, effective January 1, 1969. However, IDPA officials felt the text should include various "information" as well as the terms prescribed by the amendment. In the simplified form recommended by the ISMS Committee on Usual and Customary Fees, IDPA would agree to pay the MD for medical services provided directly to public-aid recipients. The physician, in turn, would agree to bill the department monthly for services performed by him, keep proper records and furnish information upon request. Either the physician or the department could terminate the agreement upon 30 days written notice. The committee felt that other parts of IDPA's draft—describing such matters as the general fee pattern—should be transferred to an accompanying statement that would *not* be signed.

Sympathy to Health Bills Foreseen in New Assembly

Election results promise a favorable climate for health and safety legislation in the 76th General Assembly, ISMS observers believe. The ISMS Council on Legislation and Public Affairs was to have met December 7 to plan a course of action for the Assembly session starting in January. Socio-economic measures advocated by the society include an Implied Consent bill, which would require motorists arrested on suspicion of drunk driving to take a blood-alcohol test; establishment of a Medical Review Board to weed out physically and mentally unsafe drivers; permission for hospitals to consolidate emergency-room facilities "where feasible and desirable," and per-student subsidies to medical schools. The House of Delegates next May is expected to weigh therapeutic abortion and neuro-psychiatric examination of all candidates for parole; both legislative steps were unofficially endorsed in the recent ISMS membership survey.

Chicago Trails L. A. in Medical Costs of Elderly

A retired Chicago-area couple living on a "moderate" budget of $3,970 a year would spend an average of $282 for medical care, including $148 out-of-pocket costs under Medicare programs. Social Security Bulletin listed about the same figures for Champaign-Urbana and Greater St. Louis. In the Los Angeles area, however, a $3,991 budget would include $331 for medical care.

Physicians Cautioned on IDPA Drug-Request Steps

The many physicians who have started treating Illinois Department of Public Aid cases are cautioned on the steps to follow in seeking approval of drugs not listed in the IDPA Manual. The request forms must show: (1) Patient's name and case number; (2) patient's address; (3) physician's name and address; (4) name of the specific drug; (5) diagnosis of case, and (6) circumstances requiring the drug's use. One reason for these steps is that IDPA keeps a file on each patient. The requests should be mailed to the Illinois State Medical Society, Committee on Drugs and Therapeutics, 360 North Michigan Avenue, Chicago, Illinois 60601. Many doctors incur serious loss of time by sending the requests to IDPA offices, said Dr. Robert C. Muehrcke, chairman of the ISMS drugs committee.

General Assistance Aide Cites M. D. Errors in Billing

The most frequent mistakes made by physicians' offices in filing Form #737 claims under state-supported General Assistance are: (1) setting a lump charge for the procedures —charges should be broken down; (2) omission or incomplete listing of the procedure code, and (3) failure to include the physician's signature and AMA medical education number. These mistakes were pinpointed by Donald Coates, supervisor of the General Assistance Unit of Illinois Department of Public Aid, in addressing ISMS-sponsored Workshops on Government Health Programs.

Agency's Child Care Includes 4,000 in Boarding Homes

The Illinois Department of Children & Family Services —which will mark its fifth anniversary in January—has been caring for about 13,000 youngsters in recent months. Some 4,000 of these are in boarding homes and constitute the agency's chief responsibility in medical care. C&FS is one of the agencies that have been participating in the ISMS' statewide Workshops on Government Health Programs. Three years ago ISMS was instrumental in the passage of the Abused Child Law, which C&FS administers.

By Don B. Freeman

MEDICINE IN THE SEVENTIES

ISMS Annual Convention

May 19-21, 1969

Sherman House, Chicago

IAP

ILLINOIS ASSOCIATION OF THE PROFESSIONS

Association Building

Plans to break ground for the new association building to be constructed by the Illinois Pharmacy Foundation in Rolling Meadows (near O'Hare Field) have been scheduled for spring, 1969, with occupancy planned for December of the same year.

The complex is to provide extensive facilities, catering to the Association operation, extensive reproduction facilities, a mail room, conference areas, board rooms, and joint reception area, which would be shared by all association tenants.

The fully carpeted, all electric building offers parking for 176 cars, a specially designed meeting room for the Board of Directors, with elaborate audio visual facilities, and the advantage of being just a few minutes from O'Hare Field.

National attention is centered on the venture, catering specifically to associations and designed to provide extensive facilities, which any one association could not afford individually.

Package Disaster Hospitals Project

The Illinois Veterinary Medical and Medical professions have launched a joint project to establish 70 package Disaster hospitals throughout the state. These hospitals are strategically located and provide all residents with readily available 200 bed units. The hospitals can be functional within two hours following a disaster. Several training areas have been established at Springfield, Elmhurst and Chicago to provide veterinarians and physicians to service these hospitals. This unique program and the first for the U.S. is under the direction of Dr. Max Klinghoffer, Elmhurst Memorial Hospital, Chairman of Civil Defense for the Association and Dr. Dan Parmer, Richton Park, representing the Veterinary Medical Profession.

The pioneers who fought taxation without representation should see it with representation.

Each piece of litter picked up along a highway costs 32 cents of taxpayers' money. Three pickups a year along one mile of highway cost $2,500.

New State Dental Society Officers

President—Robert L. Straub, D.D.S.
1439 W. 103rd St., Chicago
Pres.-Elect—E. E. Hoag, D.D.S.
511 Central Bldg., Peoria
Vice-Pres.—Joseph T. Brophy, D.D.S.
111 S. Harlem Ave., Forest Park
Secretary—Ralph A. Dickson, D.D.S.
Piasa 1st Federal Savings Bldg., Alton
Treasurer—Robert M. Unger, D.D.S.
2656 W. 63rd St., Chicago

New President for Pharmacy

Assuming the presidency of the Illinois Pharmaceutical Association at the 88th Annual Convention Meeting in September at the Chicago Marriott Motor Hotel was Jack T. Keefer of Mt. Prospect.

Philip Sacks of Norridge was elected as president elect.

Three vice presidents are Roger Cahill of Streator, Herbert Carlin of La Grange Park, and Daniel Mulcahy of Springfield.

Elected secretary was Paul Neumann of Aurora and Norman Garfinkel of Chicago as treasurer.

Titillating Titles

William Dart, Executive Director of the Illinois Society of Professional Engineers, must be credited with the greatest journalistic imagination among IAP Journals. His column is labeled "Dart's." When Louis Bacon was President, his column was headlined "Once over with Bacon." Current President J. P. Murphy calls his "Murphy's Chowder."



A Message for You, Doctor

By Lina Trotter

Certified Medical Assistant! These are humble words—not proud. Your Medical Assistant, contrary to what you might think, if she becomes a certified medical assistant, will not feel she "knows it all." She will be amazed that there is so much yet to learn.

Do you know that most medical assistants who are studying, either for certification or just to learn more about the field, are studying on their own free time—and that of their families? It is because she is a dedicated person who likes her work and is trying to improve it that she gives this time when she would probably really rather be spending it elsewhere. You will find that these ladies really are anxious to improve for your sake and your patient's sake more than for their own.

Why don't you get a copy of the outline for study for these examinations and find out just what a wide field certification will cover—then when your Medical Assistant comes to you and tells you she wants to study for certification you will realize this is an opportunity you really cannot afford to miss. And if you ever get a chance to talk to them on the day of examination you cannot help but be impressed by their dedication. If you are willing to help them with their studies so much the better—believe me you will have a very grateful Medical Assistant.

As of December 1967 there were 13 Certified Medical Assistants in the State of Illinois. We have not yet received the total who became certified as a result of the examinations this year. Wouldn't you like your medical assistant to become certified?

What benefits will your Medical Assistant receive from IMAA? In the field of education alone the following is available:

1. At our annual meeting we have approximately one and one half days of educational lectures.
2. An annual symposium is held usually in September with one whole day devoted to education in the form of panels, discussions and lectures.
3. In the last year we also have held a seminar which is also a one day educational project.
4. Our Newsletter; published four times a year; is filled with educational items.
5. Our executive memo is put out regularly to acquaint members with new activities, new ideas and new opportunities.
6. Study groups formed by local Medical Assistant groups throughout the State of Illinois bring educational materials to the local level. These groups are formed mainly for the purpose of education but quite a few of those who study in these groups also go on to certification.

All of these opportunities have been made possible through the combined efforts of the doctors and their loyal employees. Much of their free time has gone into this effort to help the Medical Assistant improve her education, increase her efficiency for you and your patient, and fill her with the dedication necessary for a job such as hers.

Why don't you encourage your Medical Assistant to investigate. Both you and she will be glad you did!



welcome relief for unwelcome cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT helps break down tenacious mucous secretions... tends to inhibit cough reflex... soothes irritated throat membranes ...reduces congestion in the bronchial tree. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.*

ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*

PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

41168

Poisoning As A Serious Problem

Nearly a million persons accidentally swallow poisonous materials annually in the United States. Of this number, about 2,100 die and many more sustain permanent and crippling injuries, according to statisticians of Metropolitan Life Insurance Company.

Since 1963, the death rate from such poisoning has remained at nearly 11 per million population, which is 16 percent higher than in 1960, suggesting a worsening situation in recent years. This increase in deaths due to accidental poisoning by solid and liquid substances has occurred primarily at the young adolescent and adult ages. At ages 15-24 the 1965 death rate from this cause was 7.6 per million among males and 3.4 among females—representing increases of 36 and 100 percent, respectively, over the mortality rates five years earlier. At ages 25-44 the corresponding death rates have increased about two-fifths in each sex, while at ages 45-64, the rate has remained the same for men, but has risen sharply for women.

At the preschool ages, such fatal poisoning has decreased markedly in recent years, but the danger of poisoning continues greater among very young children than at any other period of life. At age 1, the 1965 mortality from this cause was 50.3 per million among boys and 36.3 among girls. At age 2, the corresponding rates were 26.3 and 23.0. The next highest mortality rates were registered at ages 45-64, totaling 18.0 and 17.3 deaths per million men and women, respectively.

The relative importance of the various substances that cause accidental poisoning fatalities also has changed in recent years. Since 1963, the barbiturates and their derivatives have been the leading cause of fatal poisonings. In 1965, they accounted for 18 percent of all accidental deaths due to poisoning among males, and for 35 percent among females. Between 1960 and 1965, the deaths attributable to these drugs increased by three-fourths among males, and doubled among females. Barbiturates take their largest toll at the adult ages. The recent rise in fatalities due to these drugs has been greatest at ages 45-64, where they were responsible for 257 deaths in 1965.

The loss of life from nonbarbiturate drugs and medicines also has shown an uptrend. The sedatives and the analgesic and soporific drugs in this category (other than aspirin and related salicylates) caused one-sixth of all the fatal accidental poisonings in 1965. In that year, they were responsible for 202 deaths among males and 148 among females, representing an increase of about 150 percent for males and 70 percent for females as compared with 1960.

On the other hand, deaths from the ingestion of wood, denatured, and other alcohol dropped sharply from 357 in 1960 to 201 in 1965. The new figures account for 14 percent of fatal poisonings among men and 4 percent among females, in contrast to 26 and 13 percent, respectively, in 1960. These poisons no longer constitute the leading cause of accidental poisoning in the U. S. Metropolitan statisticians point out, however, that the figures may nevertheless understate the current involvement of alcohol in deaths due to poisoning. A recent study of death certificates indicated that there were 54 deaths in 1964 due to the combined effects of alcohol and barbiturates, and 29 deaths in 1964 attributed to the combined effects of alcohol and nonbarbiturate substances.

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Membership Forum

Dear Doctor: October 31, 1968

The Committee on Drugs and Therapeutics is anxious to do as good a job as possible in the area of medications for recipients of Public Aid. Due to the increasing number of physicians treating these cases, it is well to review the pertinent points regarding approval of drug requests not listed in the manual and subsequent authorization for payment.

The Illinois Department of Public Aid maintains a separate file on each patient. The recommendation form which the Committee on Drugs and Therapeutics submits to the Department must contain the following information:

1. Patient's name and case number
2. Patient's address
3. Physician's name and address
4. Drug requested
5. Diagnosis
6. Circumstances

Requests from the physicians should be mailed **directly** to the Illinois State Medical Society, Committee on Drugs and Therapeutics, 360 North Michigan Avenue, Chicago, Illinois 60601.

Many physicians are sending their requests to the Public Aid Department in their own counties. As a result, a considerable time loss occurs before the letter finally reaches its appropriate destination.

Your cooperation with respect to furnishing the Committee with the proper and necessary information will facilitate a fair appraisal of your drug requests, and will assist in the expeditious handling of each item.

Sincerely,

/S/

Robert C. Muehrcke, M.D., Chairman
ISMS Committee on Drugs and Therapeutics

Ed. note: Membership Forum *is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

(Ed. note: The following communication was addressed to Dr. Philip Thomsen, ISMS president, dated Oct. 18, 1968.)

Dear Dr. Thomsen:

I am aware of your deep interest in medical education and particularly the questions of who goes into medicine, who become family physicians, and who become specialists. I would like to tell you of research data that bears on these questions. As part of a large research project, we have extensive biographical data on approximately 630 entering first-year students in six medical schools widely distributed throughout the United States, one in Illinois. We have four types of data about each of these students:

1. Medical College Admission Test scores.
2. Personality characteristics and values based on three standardized psychometric instruments.
3. Attitudes as developed in a psychometric instrument from our laboratory called Cancer Attitude Survey. Three sets of attitudes are explored:
   a. Attitudes towards psychic resources of patients to carry the burden of catastrophic illness such as cancer.
   b. Attitudes towards the value of early diagnosis and aggressive management of cancer.
   c. Attitudes towards death including immortality and acceptance of and preparation for death.
4. Extensive biographical and environmental data from a three-page biographical inventory. This explores in depth the geographic, religious, economic, family, and educational backgrounds. Included are items involving doctors in the family, contacts with sick persons, jobs in hospitals, etc.

The students were asked on admission to medical school what fields of medicine they wished to enter. About half specified a choice. 118 listed surgical specialties. 112 family practice, 98 internal medicine or pediatrics.

We have taken each of these three groups —that is, the would-be generalists, surgeons, and internists—and compared them in each of the four areas described above. We have found significant differences in each of the four areas. For example, general practitioners were highest on the verbal and science scores on the MCAT, while the would-be surgeons were significantly lower. There were significant differences in values. The gener-

alists' value scores were low on economic and high on social and religious. The surgeons-to-be were high in economic and low on social. The internists were low on religious values. There were differences between generalists and internists in some of the attitude categories.

Some differences were seen in environmental background. A higher percentage of would-be general practitioners were apparently influenced in career choice by personal contact with physicians. Other differences were also seen.

Our data would seem to point out some of the factors in personality and background that are involved in initial desires. On the other hand, the fact that some items are so similar suggests that ultimate decisions depend more on experiences in medical school than on previous conditioning.

Sincerely yours,
Harold B. Haley, Jr., M.D.
Professor of Surgery
Stritch School of Medicine

Clinics for Crippled Children Listed

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. There will be eighteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Jan. 8 Joliet—St. Joseph's Hospital
Jan. 8 Champaign-Urbana — McKinley Hospital
Jan. 9 Springfield General—St. John's Hospital
Jan. 9 Cairo—Public Health Building
Jan. 9 Peoria Cerebral Palsy (AM.) — Allied Agencies Building, 320 E. Armstrong
Jan. 9 Flora—Clay County Hospital
Jan. 9 Sterling—Community General Hospital
Jan. 10 Chicago Heights Cardiac — St. James Hospital
Jan. 14 Quincy—St. Mary's Hospital
Jan. 14 East St. Louis—Christian Welfare Hospital
Jan. 14 Peoria General—Children's Hospital
Jan. 15 Hinsdale—Hinsdale Sanitarium
Jan. 15 Evergreen Park—Little Company of Mary Hospital
Jan. 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
Jan. 16 Rockford — Rockford Memorial Hospital
Jan. 16 Decatur—Decatur & Macon Co. Hospital
Jan. 24 Chicago Heights Cardiac—St. James Hospital
Jan. 28 East St. Louis—Christian Welfare Hospital
Jan. 28 Peoria General—Children's Hospital
Jan. 29 Elgin—Sherman Hospital
Jan. 29 Centralia—St. Mary's Hospital
Jan. 29 Springfield Cerebral Palsy—Diocesan Center
Jan. 29 Mt. Vernon—Good Samaritan Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

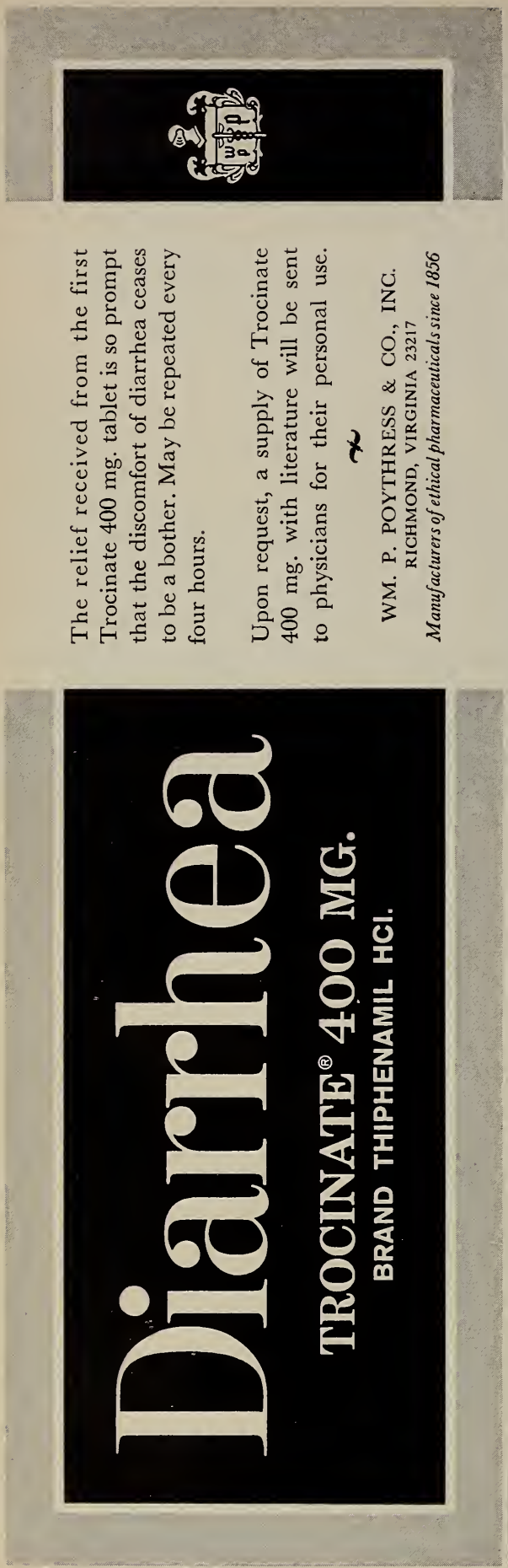
A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017



NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturers' package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

REPOISE Ataraxic ℞

Manufacturer: A. H. Robins Co.
Nonproprietary Name: Butaperazine Maleate
Indications: Chronic schizophrenia
Contraindications: Coma, circulatory collapse, bone marrow depression, history of jaundice, blood dyscrasias or hypersensitivity related to other phenothiazines.
Dosage: Adults: 5-10 mg. tid, increase by 5-10 mg. every few days until maximum response is obtained. Dosages exceeding 100 mg. daily are not recommended.
Supplied: Tablets—5, 10 and 25 mg. base; bottles of 100 and 500.

DUPLICATE SINGLE PRODUCTS

AMCILL Antibiotic—Penicillin ℞

Manufacturer: Parke, Davis & Co.
Nonproprietary Name: Ampicillin trihydrate
Indications: Infections due to susceptible strains of Gram-negative or Gram-positive bacteria.
Contraindications: Hypersensitivity to penicillin, infections due to penicillinase-producing bacteria.
Dosage: Adults: 250-500 mg., q6h.
Children: 50-100 mg./kg./day in divided doses 3-4 times daily.
Supplied: Capsules—250 and 500 mg.; bottles of 24 and 100.

AMCILL-S Antibiotic-Penicillin ℞

Manufacturer: Parke, Davis & Co.
Nonproprietary Name: Ampicillin, sodium
Indications: Infections due to susceptible strains of Gram-negative or Gram-positive bacteria.
Contraindications: Hypersensitivity to penicillin, infections due to penicillinase-producing bacteria.
Dosage: Adults: 250-500 mg., q6h.
Children: 25-50 mg./kg./day in divided doses, q6h.
Supplied: Vials (powder)—250 and 500 mg.

GYNOREST Hormone—Progesterone ℞

Manufacturer: Mead Johnson Laboratories
Nonproprietary Name: Dydrogesterone

(Continued on page 804)



"Will I ever catch up on my work?"

Mebaral® usually calms the anxious patient without the degree of languor, or decrease in alertness often caused by other barbiturates.[1] Mebaral is particularly valuable in treating anxiety-tension states *when minimal hypnotic action is desired.*[2] Its sedative action is prolonged[3] and predictable.

Contraindication: Large doses are contraindicated in patients with nephritis.

Warning: May be habit forming.

Precautions: As with other barbiturates, caution is advisable during use in debilitated and senile patients and in patients with pulmonary disease.

Adverse reactions: Although Mebaral is generally well tolerated over long periods, the possibility of idiosyncrasy to barbiturates (as manifested by drowsiness, vertigo, and cutaneous eruptions) should be considered.

Dosage: *Adults,* for daytime sedation—½ gr. (32 mg.), ¾ gr. (50 mg.) and, at times, 1½ gr. (100 mg.), three or four times daily.

References: 1. Musser, Ruth D., and Shubkagel, Betty L.: Pharmacology and Therapeutics, ed. 3, New York, Macmillan Company, 1965, p. 363. 2. Council on Drugs, American Medical Association: New Drugs 1965, Chicago, American Medical Association, 1965, p. 157. 3. Modell, Walter (Ed.): Drugs in Current Use 1966, New York, Springer Publishing Company, 1966, p. 77.

Winthrop Laboratories
New York, N.Y. 10016

Winthrop

Mebaral®

tablets:
32 mg. .....(½ grain)
50 mg. .....(¾ grain)
100 mg. .....(1½ grains)

brand of

mephobarbital

DEPENDABLE DAYTIME SEDATION

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R-6062

New Pharmaceutical Specialties

(Continued from page 802)

Indications: Primary dysmenorrhea, primary and secondary amenorrhea, endometriosis, threatened and habitual abortion due to progesterone insufficiency, infertility due to inadequate luteal activity, pregnancy test.
Contraindications: None known.
Dosage: Determined by indication for which it is used.
Supplied: Tablets— 5 mg.; bottles of 50
10 mg.; bottles of 100

COMBINATION PRODUCTS

TRIND-DM Cough Preparation o-t-c
Manufacturer: Mead Johnson Laboratories
Composition: Each 5cc. contains:

Phenylephrine HCl	2.5 mg.
Acetaminophen	150.0 mg.
Dextromethorphan HBr	7.5 mg.
Glyceryl guaiacolate	50.0 mg.
Alcohol	15 %
Chloroform	0.1 %

Indications: Symptomatic treatment of coughs and colds
Contraindications: None mentioned
Dosage: Children 3 to 6 years: 1 tsp. q.3-4h.
6 to 12 years: 2 tsp. q.3-4h.
Adults: 2-4 tsp. q.3-4h.
Supplied: Syrup—bottles of 4 fl. oz.

VI-DAYLIN Plus IRON Vitamins—Multiple o-t-c
Manufacturer: Ross Laboratories
Composition: Vitamins A, B complex, C, D, niacinamide, ferrous fumarate.
Indications: Nutritional supplement
Contraindications: None mentioned
Dosage: One tablet daily
Supplied: Tablets, chewable; bottles of 60.

NEW DOSAGE FORMS

AMCILL Drops Antibiotic—Penicillin ℞
Manufacturer: Parke, Davis & Co.
Nonproprietary Name: Ampicillin trihydrate
Indications: Infections due to susceptible strains of Gram-negative or Gram-positive bacteria.
Contraindications: Hypersensitivity to penicillin, infections due to penicillinase-producing bacteria.
Dosage: Infants: up to 5 kg.—62.5 or 125 mg. q6h.
5-7.5 kg.—94 or 188 mg., q6h.
7.6-10 kg.—125 or 250 mg. q6h.
Supplied: Pediatric Drops—100 mg./cc; bottles of 20 cc with dropper. (to be reconstituted)

AMCILL Suspension Antibiotic—penicillin ℞
Manufacturer: Parke, Davis & Co.
Nonproprietary Name: Ampicillin trihydrate
Indications: Infections due to susceptible strains of Gram-negative or Gram-positive bacteria.
Contraindications: Hypersensitivity to penicillin, infections due to penicillinase-producing bacteria.
Dosage: Adults: 250-500 mg. q6h.
Children: 50-100 mg./kg./day in divided doses 3-4 times daily.
Supplied: Oral Suspension—125 and 250 mg./5cc.; bottles of 80 cc. (To be reconstituted)

PFIZERPEN Antibiotic—Penicillin ℞
Manufacturer: Pfizer Laboratories
Nonproprietary Name: Penicillin G, Potassium
Indications: Mild to moderately severe infections caused by penicillin-susceptible pathogens.
Contraindications: Hypersensitivity to it.
Dosage: 400,000 U. q.i.d., taken on an empty stomach.
Supplied: Powder for Syrup—400,000 U./5 cc.; bottles of 80 and 150 cc.

Is it depression?

She says "I'm always on edge..."

...but her other symptoms: depressed mood, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.



when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

(Continued from page 729)

COOPERATION IN MEDICAL TESTIMONY

Mr. Frank Pfeifer, ISMS legal counsel, called attention to the request for cooperation in the provision of medical testimony before the Medical Examining Board on the question of revocation and suspension of licenses. He outlined in detail the procedure to be followed with regard to the presentation of testimony.

Counsel further indicated that the Committee on Medical Practice and Quackery had requested a report to the Trustees that the committee had approved a plan of cooperation with the Department of Registration and Education. The Committee requested that it be allowed to implement its plan to provide physicians in medical cases where medical testimony was needed before the Department. The plan of cooperation with the Department of R. and E. regarding medical testimony was adopted.

USUAL AND CUSTOMARY FEES PROCEDURES

The U. & C. Committee has discussed two major issues; one concerns the IDPA method of processing individual physician's claims, the other methods used by IDPA in arriving at a statistical report on physician payments. A frequent error is that physicians are not billing at their usual and customary fee but at figures furnished from other sources. A statistical report was noted with regard to increases in the Consumer Price Index and in doctors' fees. It emphasized that the rise in doctor's fees was commensurate with the rise in the Consumer Price Index.

MALPRACTICE SCREENING PANEL O.K.'D. FOR DISCUSSION

The Board authorized the Medical-Legal Council to pursue its discussions further with the Illinois Bar Association regarding the possible establishment of a Malpractice Screening Panel. The proposed panel would hear evidence and review claims on a closed-door basis before litigation is pursued.

ISMS TO ACT AS FRIEND OF THE COURT

A group known as the Illinois Pure Water Committee has filed suit in Madison County challenging the legality of the new Fluoridation Act. At the request of Dr. Yoder, ISMS has taken steps to intervene, along with the Dental Association.

ISMS TO REQUEST REDEFINITION WITH REGARD TO RMP

The ISMS will request the next National Administration on Capitol Hill to have the Secretary of HEW supplement his National Advisory Committee on RMP with a list of practicing physicians (furnished by the AMA) who will attempt to define more specifically what related diseases are to be included in regional medical programs before enactment of any further health legislation. This is the substance of a resolution to be presented by ISMS at the AMA convention.

(Abstracts continued on page 810)

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(Continued from page 806)

SCHOOL HEALTH EXAMINATION RECORD RECONSIDERED

The Board was informed that the Committee on Child Health approved the proposed School Health Examination Record together with a suggestion that space be provided for recording blood pressure and the type of Tuberculin test administered on the record, as well as dates. A written minority report in relation to this was read. Following extended discussion, the matter was referred back to the Committee on Child Health for reconsideration.

SURVEY RESULTS TO BE BASIS FOR ACTION

Dr. Frank Jirka, chairman of the Board, indicated that Mr. Roger White, executive administrator, had been directed to prepare a plan for referral of each of the items of the membership survey to appropriate Councils and Committees for follow-up study and possible implementation plans.

NURSING COMMITTEE TO STUDY SCHOOLS OF PRACTICAL NURSING

The Chicago Council on Community Nursing requested that ISMS endorse a resolution on Schools of Practical Nursing aimed at forcing the closing of schools of practical nursing operated under the Vocational School Act. Upon the recommendation of the Executive Committee, the Board agreed that this matter be referred to the Nursing Committee for further study.

AUDIOMETRY AND HEARING CONSERVATION

Dr. Edward A. Pizsczek, chairman, Public Health Committee, recommended approval of a training program to provide instruction in audiometry and hearing conservation. A July 12, 1968 letter from Dr. Franklin D. Yoder, outlined the program and requested endorsement of the Society. The Board approved.

ISMS TO PRESENT RESOLUTION TO AMA

Dr. Willard Scrivner requested that the ISMS express its concern to both State and Federal legislators that all funds and grants henceforth allowed medical schools be tied in some way to a formula for the end product of medical schools, i.e., graduates. A resolution will be presented to the AMA House of Delegates at the Miami meeting establishing this as national policy.

COOPERATION WITH NATIONAL CENTER ENDORSED

Upon the request of Dr. Franklin D. Yoder, director, Illinois Department of Public Health, and upon the recommendation of the Executive Committee, the Board endorsed cooperation with the National Center for Health Statistics in relation to scientific studies based on death certificates.

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***Dr. Melvin L. Afremow,** Chicago, a physician for more than 35 years, died Oct. 18 at the age of 63. He was consulting physician at American and Columbus Hospitals, attending physician for the Illinois Nursing Training School.

Dr. John Bellucci, Frankfort, founder and owner of Bellucci Medical Clinic, died Oct. 14 at the age of 61.

***Dr. Grover C. Bullington,** Torrence, Calif., a longtime Pana physician, died Oct. 4 at the age of 83. He was past president of Christian County Medical Society.

***Dr. Audley F. Connor,** Chicago, who was head of medicine at Provident Hospital for 20 years, died Oct. 30 at the age of 68.

***Dr. Claire E. Healey,** Chicago, a physician for the Illinois Department of Public Health for the past 20 years, died Oct. 4 at the age of 73.

***Dr. Charles E. Hildreth,** 84, a practicing physician in Mount Pulaski for more than 50 years, died Oct. 21. He was a member of ISMS Fifty-Year Club.

Dr. Julius B. Kahn, Jr., Winnetka, died Oct. 18 at the age of 47. He was professor and chairman of the department of pharmacology in the Northwestern University Medical School.

***Dr. Charles J. Kurtz,** Chicago, a faculty member of Northwestern University Medical School for more than 50 years, died Oct. 29 at the age of 96. He was a member of ISMS Fifty-Year Club.

***Dr. I. W. Lee,** Casey, a practicing physician for 60 years, died Oct. 2 at the age of 91. He was a member of ISMS Fifty-Year Club.

***Dr. Paul Magnuson,** 84, founder of the Rehabilitation Institute of Chicago, died Nov. 5. He was the first medical director of the Illinois Industrial Commission and a member of ISMS Fifty-Year Club.

***Dr. Clarence C. Saelhof,** Auburndale, Fla., a practicing physician for nearly 40 years, died Oct. 29 at the age of 70.

***Dr. Vito Vighi,** 63, of Ottawa, a physician and surgeon for 35 years, died Oct. 27.

Dr. John P. Walker, Lincoln, a member of the medical staff at Lincoln State School, died Sept. 28 at the age of 51.

***Dr. Doris Wheeler,** Evanston, died Oct. 29 at the age of 52 in Michael Reese Hospital where she was on the hospital staff.

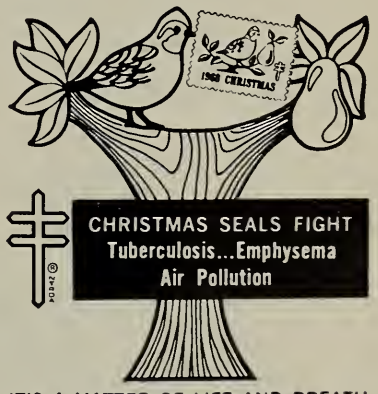
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THE VIEW BOX

(Continued from page 754)

Diagnosis: Cystitis emphysematosa.

Cystitis emphysematosa is an inflammatory lesion of the bladder associated with gas vesicles in the bladder wall. The condition is usually caused by gas forming bacilli of the colon group and often is associated with diabetes mellitus or hyperglycemia due to intravenous fluid therapy. Rarely, diabetes without infection can produce this entity. This disease is usually very transient and benign; 21 days has apparently been the upper limit of the extent of the duration of the disease. The radiographic picture will vary with the stage of the disease. Three stages are described.

Stage 1: A clear zone 1 mm. wide may be seen around the contrast media in the bladder. There is no free gas in the lumen. The gas vesicles are so small that they cannot be distinguished radiographically.

Stage 2: The bladder wall is irregular, swollen, and thicker due to increased intramural gas production. The gas filled vesicles can now be made out clearly in the wall of the bladder. There is no gas in the bladder lumen. Bladder capacity has diminished.

Stage 3: The vesicles are ruptured and free gas appears in the lumen of the bladder with less gas demonstrable in the wall. The capacity of the bladder returns to normal but later diminishes in size. Still later the amount of free gas diminishes and the bladder returns to normal. As the infection is brought under control the radiographic appearance will disappear rapidly. Our case is a good demonstration of Stage 2. When Stage 3 occurs it may be accompanied by clinical pneumaturia.

Reference:

Ney and Friedenberg, *Radiographic Atlas of the Genitourinary System*. Lippincott, 1966, pages 490, 491.

Hunters who use corrective glasses are urged to make certain they are of the safety variety. Impact-resistant lenses will more adequately protect the eyes from stray pellets, ejecting shells, twigs and other dangers, without reducing visibility, advises the National Society for the Prevention of Blindness.

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PERITONEOSCOPY, Two Weeks, March 17
ULTRAVIOLET CYSTOSCOPY, 1-1/2 Days, March 24
SYMPOSIUM ON SHOCK, Two Days, December 20
ESOPHAGEAL SURGERY, Three Days, March 27
BASIC INTERNAL MEDICINE, One Week, March 3
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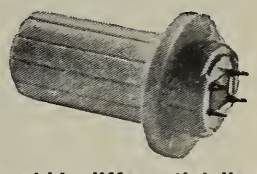
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IDPA Payments Procedures

(Continued from page 773)

DO YOU HAVE ANYTHING MORE TO ADD REGARDING PRECISION IN BILLING?

I think it would be beneficial to relate more specifically the functions of the patient's identification card, the CPT, and the form 132 for billing the department. Perhaps the best way to do this is to trace all actions from the moment a patient calls on the physician until the money warrant arrives in payment of services. Some complicated procedures will serve as examples with commentary on how to accomplish precision and to avoid pitfalls.

Answers to this question will be the theme of next month's installment.

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Twenty thousand brochures calling attention to an amendment to Illinois' Child Abuse Law have been mailed to physicians, hospitals, child welfare personnel and law enforcement agencies by the Department of Children and Family Services.

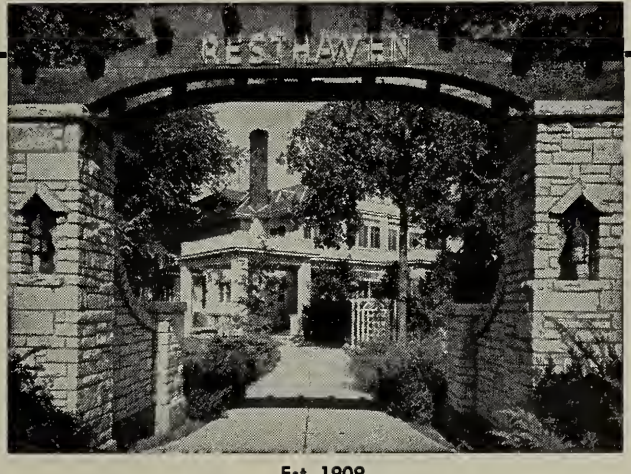
The amendment, signed into law by Gov. Samuel H. Shapiro, specifies "evidence of malnutrition" as a form of suspected child abuse that must be reported to the department by doctors and hospital administrators.

"Child abuse is an even greater problem than we suspected when the Illinois Child Abuse Law was passed in 1965," said Edward T. Weaver, department director. Of the 1,500 cases of suspected abuse occuring in the last 39 months, more than 200 cases involved malnutrition as a form of abuse, according to Weaver.

"Starving a child to death is just as cruel, or possibly more cruel, than fracturing his skull," said Weaver, "and now the law spells this out clearly."

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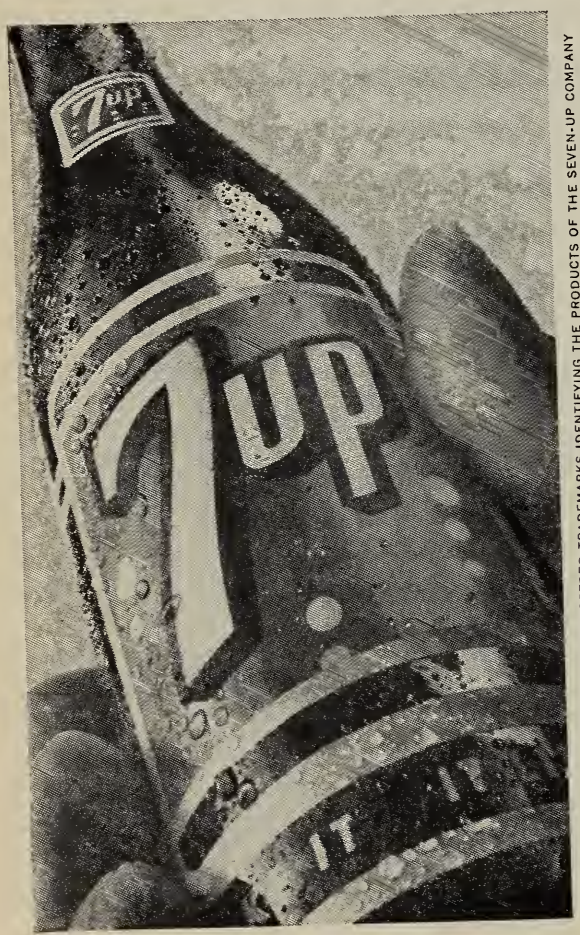
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